Title

An investigation of the experience of the role of Critical Incident Debriefer in a 'Fire and Rescue Service in the North West of England'

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Dissertation submitted to the University of Chester for the Degree of Master of Science (Psychological Trauma) in part fulfilment of the Modular Programme in Psychological Trauma, October 2015.

Abstract

AIMS: Psychological debriefing is a crisis intervention for use with people who are exposed to stressful events within their work. Research on crisis interventions is controversial, and further studies in this field are important to establish appropriate interventions for emergency workers. Debriefing has become an area for debate due to evidence of its benefits showing beneficial and negative outcomes, or no outcome at all. This study aims to qualitatively investigate the experience of the role of Critical Incident Debriefer in a Fire and Rescue Service in the North West of England.

METHODS OF RESEARCH: A phenomenological approach was used to collect data via Collaborative Inquiry (CI) group meetings with the debriefers. The recorded CI meetings were transcribed into text and the transcripts were analysed using applied thematic analysis. A reflective diary was utilised to keep experiences, thoughts, feelings and opinions visible and an acknowledged part of the research.

RESULTS: Review and analysis of the participants' experiences identified six themes; policy concerns; organisational concerns; CID training; psycho-education; culture and the future of CID.

CONCLUSION: These findings identified positive and negative elements of the CID process from the perspective of debriefers. Attitudes towards CID appear to be improving, however, debriefers feel they do not receive appropriate training, which corresponds with the findings of the Cochrane Review (2002) and suicide within the fire service is a serious concern.

Declaration

The work is original and has not been submitted previously in support of any qualification or course.

Signed:

Acknowledgements

I would like to thank a number of individuals for their help and support, without whom this dissertation would not have been possible. Primarily, I would like to thank Dr Stuart McNab for all his invaluable guidance and supervision. Special thanks go to Dr Rebekah Lwin, who always believed in me and offered encouragement. It is a pleasure to thank Professor Gordon Turnbull who has been an enormous inspiration and his advice has kept me going through the ups and downs of this journey.

This dissertation would not have been possible without the professional co-operation of the Fire Service Critical Incident Debriefers and supporting staff. I would like to say a huge thank you to the Debriefers who have a passion for this subject and due to their dedication they managed to find time in their busy schedules to share their experiences of CID.

I would like to express my sincere gratitude to my partner Greg, whose encouragement and support have given me continued courage to follow my passion. A special thank you to my Mother and Father for all the sacrifices they have made on my behalf, words cannot express my deep appreciation and love.

Finally, I would like to dedicate this work to my beautiful Mother who sadly lost her battle against cancer whilst I was working on this research.

Table of Contents

External File Attachments

- Powerpoint Presentation to Fire Service Consultation, Research and Assurance Group
- Powerpoint Presentation to Fire & Rescue Service Critical Incident Debriefers

List of Abbreviations

APA	-	American Psychology Association
ATA	-	Applied Thematic Analysis
CI	-	Collaborative Inquiry
CID	-	Critical Incident Debriefing
CISD	-	Critical Incident Stress Debriefing
CISM	-	Critical Incident Stress Management
CRAG	-	Consultation Research and Assurance Group
DSM-III	-	Diagnostic Manual of Mental Health Disorders 3
DSM-V	-	Diagnostic Manual of Mental Health Disorders 5
EFC	-	Emergency Fire Crews
PD	-	Psychological Debriefing
PTG	-	Post Traumatic Growth
PTSD	-	Post Traumatic Stress Disorder
RCT	-	Randomised Controlled Trials
TRiM	-	Trauma Risk Management
TRU	-	Technical Rescue Unit
VT	-	Vicarious Trauma

Table of Figures / Tables

CHAPTER ONE

INTRODUCTION

TO THESIS

CHAPTER 1

Introduction to Thesis

This study aims to review and add to the existing literature on Critical Incident Stress Debriefing (CISD) within the emergency services by exploring the role of Critical Incident Debriefer within a Fire and Rescue Service in the North West of England. CISD is a supportive crisis intervention process, created for groups of emergency service personnel and disaster workers following critical incidents (Mitchell, 1983; Dyregrov, 1989; Mitchell & Everly, 1997). The study will be approached from a phenomenological viewpoint, which seeks to provide a description of lived experiences, perceptions and emotions, achieved via, 'Collaborative Inquiry (CI) Groups' with the 'Debriefers'. CI Groups invite individuals with the same interest, to be co-researchers in a study, to gain experience and knowledge from those involved, which provides valuable qualitative data. The data will then be analysed via Applied Thematic Analysis. Thematic analysis aims to describe and interpret participants' views, which will help decipher the data, keeping within the phenomenological philosophy. Additional data provided by the Fire & Rescue Service will be utilised.

Following this introduction there will be an extended literature review, followed by a rationale; a journal article and a discussion on the findings of the study, including methodological considerations, limitations encountered, an exploration of future research and consideration of possible ethical issues. Finally a reflexive statement and conclusion will be presented.

The journal article, will be presented in a form ready for publication, this will include a précised version of the Literature Review; Rationale; Research Aims and Objectives;

Methodology and a Discussion of the presented results. Finally, a conclusion will be presented, highlighting the main findings.

This research will be submitted for publication in the Journal of Traumatic Stress. This will contribute to the field of psychological debriefing within the emergency services, aiding continued development and knowledge within this organisational population. This Journal follows the style recommendations of the 2010 Publication Manual of the American Psychological Association [APA], sixth edition and has a word restriction of 6000 words. The first author of this article is Tracy Haynes, the second is Dr Stuart McNab, Director for the Centre for Research and Education in Psychological Trauma and Senior Lecturer on the MSc Psychological Trauma, who supervised the first author, providing continued support and expert knowledge throughout.

Search strategy

The principle researcher used online search engines; EBSCO, CINAHL Plus; MEDLINE; PsycARTICLES; PsycBOOKS; PsycINFO; SocINDEX to collect relevant literature using key words to locate scientific articles pertaining to CISD and fire fighters.

Key words

Key words used to conduct searches included; Psychological debriefing; Fire fighters & Stress; PTSD & Fire fighters; PTSD & Emergency Services; Psychological debriefing & Fire fighters; CISD & Fire fighters.

CHAPTER TWO

EXTENDED LITERATURE REVIEW

CHAPTER 2

Literature Review

This literature review will examine key issues surrounding fire-fighters and trauma including Critical Incident Stress Management (CISM), Critical Incident Stress Debriefing (CISD), the controversy surrounding Debriefing, preferences for interventions, Post Traumatic Stress Disorder (PTSD) and fire-fighters, resilience and growth and trauma response.

Fire-fighters and Trauma

Fire-fighters experience traumatic events involving human pain and suffering on a daily basis, rescuing people from burning buildings, extricating people trapped in vehicles and caring for the seriously injured and vulnerable. They cope with this by utilising strong support mechanisms within watches and employing coping mechanisms such as humour for example, however, occasionally, a particular incident can have a lasting impact. Researchers have studied the impact that repeated exposure to traumatic events can have on emergency workers, recognising that it can result in stress related symptoms, such as PTSD (Bryant & Harvey, 1996; Marmar, Weiss, Metzler, Delucchi, Best & Wentworth, 1999; Regehr, Hill, & Glancy, 2000; Berger, Coutinho, Figueira, Marques-Portella, Luz, Neylan & Mendlowicz, 2012). Due to the nature of their work fire-fighters may experience an elevated risk of developing PTSD (Corneil, Beaton, Murphy, Johnson, & Pike, 1999; McFarlane & Bryant, 2007). Symptoms can include; guilt about surviving, feelings of detachment, depressive mood, social dysfunction, dissociation, anger and irritability, alcohol and

substance misuse (Haslam & Mallon, 2003), causing an impact on fire-fighters and their families (Regehr & Bober, 2005).

Research has examined stress responses to major traumatic events (McFarlane, 1988; Marmar, Weiss, Metzler, Ronfeldt & Foreman, 1996; Beaton, Murphy, Johnson & Nemuth, 2004), however, fire-fighters are more commonly exposed to smaller scale traumatic events such as road traffic accidents or suicides (Regehr & Bober, 2005), that have not made headlines and do not result in the surge of public support. Marmar et al. (1996) found that the impact of small-scale incidents on emergency workers was equivalent to that of larger scale events. This suggests that the psychological responses to daily operations need to be considered in terms of prevention and early detection of psychological problems. The findings in Marmar et al. study suggest that immediate responses at the time of the critical incident should be taken into consideration. They found that workers who felt less adequately prepared to attend to the task presented to them, felt more personally threatened, more helplessness, grief and guilt, amongst other negative emotions and were more likely to be in greater distress approximately one and a half to four years later. This highlights the importance of training emergency personnel to manage the emotionally unsettling and at times horrific experiences that can occur in daily emergency work (Marmar et al. 1996).

Clinical experience and literature have produced a list of events that may cause the most distress. These events include incidents involving children; which have been reported to be the most traumatic and subsequently lead to emergency workers experiencing intrusive memories (Clohessy & Ehlers, 1999); the death of a co-worker in the line of duty (Beaton, Murphy, Johnson, Pike, & Corneil¸1998; Meyer, Zimering,

Daly, Knight, Kamholz & Gulliver, 2012) and the death of a patient in the responders care (Regehr & Bober, 2005). Other stresses can derive from organisational problems, shift work and sleep disruption (Murphy, Beaton, Pike & Johnson, 1999; Clohessy & Ehlers, 1999). One response to the symptoms fire-fighters may experience following a particular traumatising event is CISM.

Critical Incident Stress Management (CISM)

CISM was originally devised for US emergency medical services personnel in the early 1980s (Mitchell, 1983). Everly, Flannery and Eyler (2002) depict the complete CISM crisis intervention system as one that employs a multi-component programme, consisting of; small group crisis interventions (CISD, defusing); large group crisis interventions (demobilizations, crisis management briefings, town meetings); individual crisis counselling (face to face, telephonic); family crisis intervention, and mechanisms for follow up and referral for formal assessment and/or psychotherapy. Additionally, it aids the early detection and treatment of post-trauma responses and other psychological sequelae (Regal, 2007). The controversy occurred when interest was focused on CISD, one element of CISM. CISD became the focus for research due to an inaccurate belief that this particular component of the model would prevent the development of PTSD per se, and was a standalone procedure (Regal, 2007). The following section will examine CISD.

Critical Incident Stress Debriefing (CISD)

CISD was distributed as a programme: “designed by an emergency person for emergency people” (Mitchell & Bray, 1990, p. 89). It is a seven-phase process and

offers a structured approach for examining thoughts and emotions with mental health professionals following critical incidents. It is not psychotherapy, nor a substitute for psychotherapy. It aims to inform and empower by normalising common reactions to trauma and providing information regarding coping strategies and further support if needed (Mitchell, 1983). After experiencing a traumatic event, psychological responses such as feelings of detachment, anger and irritability are reasonably common (Bisson, Brayne, Ochberg & Everly, 2007); however, there appears to be some uncertainty regarding the best way to react to them. Some argue that early psychological interventions after traumatic events are a key feature of a comprehensive range of care (Everly & Mitchell, 1999). However, others argue that early application of prescribed psychological interventions, to anyone implicated, has no valuable role in post trauma responses, believing instead that good social support is the solution to the prevention of later mental health complications (Wessley, 2005; Haslam, & Mallon, 2003).

The field has grown considerably, with little empirical evidence of its effectiveness, with many CISD programs being employed and fire-fighters being trained as debriefers (Harris, Baloglu & Stacks, 2002). Although the evidence for the use of group psychological debriefing is limited, lack of support through well-designed studies is not evidence that CISD does not work, it basically means that high-quality research that empirically assesses the efficacy of the treatment has not yet been conducted (Suveg, 2007).

Awareness of CISD with regards to fire-fighters has developed over recent years; some researchers report that debriefing protects fire-fighters from stress related disorders, such as PTSD, encouraging its need and success (Robinson & Mitchell,

1993). Others believe it has no benefits and should cease (Rose, Bisson, Churchill & Wessley, 2002). The Cochrane Review (Rose et al. 2002) recognised that there was a lack of appropriate training for those facilitating psychological debriefing. Little faith in the competence of debriefers was also expressed in Durkin and Bekerian (2000) study on psychological resilience to stress in fire-fighters with the Home Office (2000) report 'Fit for Duty?' warning of the cost of a well-intended but unskilled intervention (p. 73, 21.25). However Wagner (2005), after reviewing all the available literature regarding the effectiveness of CISD for use with emergency service workers, concludes that for this population, the call for the removal of current programmes using CISD is unwarranted. This view is supported by Kinchin (2007), who advocates that throughout the early part of the twenty-first century, a 'myth' was established that early intervention was of little or no assistance and may actually do harm, however, this was a striking difference of opinion to that expressed by traumatised people. While this myth, with its ensuing debate, may assist with critically reviewing the early responses that aid people following traumatic incidents, there is also a grave danger of rejecting the essential along with the inessential (Dyregrov, 2003). It appears that the main reason for the recommendations to cease debriefing is the primary principal medical ethics of 'do no harm' (Hawker, Durkin & Hawker, 2011). Nevertheless, one has to consider the harm done by withdrawing an intervention from occupational groups who have been relying on it to help them cope with working in extremely difficult circumstances for over 20 years (Hawker et al. 2011).

Controlled studies have identified positive outcomes for emergency service workers who were debriefed; comparative to those who were not debriefed (Eid, Johnsen, & Weisareth, 2001; Deahl, Srinivasan, Jones, Thomas, Neblett & Jolley, 2000). It is,

however, frequently suggested that psychological debriefing has little benefit to those suffering from PTSD, which of course is accurate, as it is not intended for PTSD sufferers; it is intended as a crisis intervention approach implemented within the first 2 weeks following exposure to an incident (Regel, 2007). Diagnosis of PTSD can only be made if symptoms have persisted for more than one month after exposure to a traumatic event (5th ed.; *DSM-5*; American Psychiatric Association, 2013). Everly et al. (2002) refer to CISD as not designed to be a single intervention outside of the multi-component 'CISM' programme, but intended to be only one constituent.

It is recognised that psychological debriefing may do harm if too short, too probing, conducted too soon or delivered by debriefers' with insufficient training or experience (Hawker et al. 2011). Recommendations for research on: "appropriate debriefing for occupational groups briefed to work in stressful situations" [is urgently needed] (Hawker et al. p. 453). Debriefing has become an area for debate due to efforts to establish empirical evidence for its benefits generating positive and negative results or no results at all (Wessely & Deahl, 2003), therefore further research focusing not only on what may be effective, but also on what is acceptable to fire-fighters would be beneficial (Jeanette & Scoboria, 2008).

Preferences for Interventions

A survey of fire-fighters preferences for intervention varied by severity, as no intervention was viewed unfavourably across scenarios; therefore, support was perceived as desirable (Jeanette & Scoboria, 2008). Informal discussion received consistently high ratings, thus respondents sanctioned the importance of a robust, informal institutional culture in managing everyday challenges (Jeanette & Scoboria,

2008). For scenarios of greatest severity, both one to one and CISD were endorsed (Jeanette & Scoboria, 2008). Several studies report that a high proportion of people who received debriefing found it to be beneficial (Arendt & Elklit, 2001; Wessely & Deahl, 2003). However, Rose et al. (2002) found that single session individual debriefing did not decrease psychological distress, nor thwart the onset of PTSD and there was no evidence that debriefing reduced general psychological morbidity, anxiety or depression, concluding that, “compulsory debriefing of victims of trauma should cease.” (p. 2). This conclusion is supported by research cited by Alderton (2010) that a single intervention following trauma may be of no help, or even detrimental, and is positively discouraged, however, equally identifying that the most important recommendations to have materialised from research is that psychological support that is, "integrated into a multiple contact model of post-incident management..." [presents positive outcomes consistently.] (p. 1). Richards (2001) study showed that despite its obligatory methodological concessions, embedding CISD within an integrated CISM system can considerably decrease the levels of long-term morbidity in crime victims, compared to both standalone CISD interventions and morbidity levels reported elsewhere.

Fire-fighters in Jeanette and Scoboria (2008) study revealed that debriefing may appeal to some, whereas others may feel uncomfortable with the group process. Several fire-fighters wrote that the individual crew and fire-fighters need to be considered before an intervention is implemented. Informal discussion, CISD, and one-to-one are different interventions, yet the results of Jeanette and Scoboria (2008) study found that they are almost equally preferred. Harris, Baloglu and Stacks (2002) note that future research should address individual differences and the hypothesis of diathesis-stress, which takes into consideration both biological and

genetic traits; "Such a hypothesis, if supported, would bring into question policies of mandatory intervention for all fire-fighters exposed to critical incidents..." *(p. 233).* Harris et al. (2002) point out that seeking personal mental health treatment in the environment of one's workplace may not be in the best interest of those concerned. They suggest a more sound policy could perhaps be 'employee assistance programmes' with individualised interventions, monitoring and more effective pre-employment screening.

Controversy Surrounding Debriefing

The assails on debriefing have been some of the most scathing seen in 40 years in the field of counselling and psychotherapy (Gist & Lubin, 1999). These attacks have been especially virulent in regard to Mitchell and Everly's (1995) CISD Model. Controversially, several randomised controlled trials concluded that debriefing did not reduce psychological distress, nor prevent the onset of PTSD, two of which warned that debriefing appeared to be harmful (Bisson, Jenkins, Alexander & Bannister, 1997; Mayou, Ehlers & Hobbs, 2000) and led to major reviews warning practitioners not to offer debriefing (Rose et al. 2002; Van Ommeren, Saxena & Saraceno, 2005). However, these warnings are founded on studies implementing an intervention that is very different from the interventions used for disaster workers, yet, subsequently, many organisations ceased to offer debriefing to their employees (Hawker et al. 2011). The findings in these studies have also been criticised for not following protocol, (timing, duration, training and independence of the debriefer). In addition, debriefing was intended for groups, whereas the participants in these studies were primary victims. Furthermore, the patients who received debriefing reported more severe initial symptoms than those who did not. Debriefing, therefore, was used with

individuals for whom it was not originally intended (Hawker et al. 2011). These results therefore do not appear conducive to, or reflect, the debriefing of emergency workers. It appears that experimental studies of CISD have created little supportive evidence. Further research is needed to strengthen the current knowledge regarding debriefing and the emergency services, acknowledging consideration of PTSD.

PTSD and Fire-fighters

PTSD has been acknowledged throughout history, with the earliest reported use of this term being *soldiers' heart* (Da Costa's Syndrome) in the American Civil War in 1862 (Kinchin, 2007). The diagnosis of PTSD as we identify it today, was not recognised until 1980, when symptoms exhibited by veterans and civilians who had experienced trauma, were for the first time grouped together under the diagnosis of PTSD and recognised in the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed.; DSM-III; APA, 1980). Prior to that, the symptoms of PTSD were largely referred to as *combat fatigue*, *shell shock* and *lack of moral fibre* (Kinchen, 2007). The latest version, DSM-5, diagnostic criteria for PTSD includes 8 criteria, which are categorised from A-H, which includes exposure to a traumatic event that meets definite requisites and symptoms from each of the four symptom clusters (Criterion B,C,D & E). Criterion F concerns the duration of symptoms; Criterion G assesses functioning; and Criterion H clarifies symptoms as not ascribed to a substance or co-occurring medical condition. In addition to meeting criteria for diagnosis, a person can experience high levels of 'Depersonalization', which is when someone feels like an outside observer, or detached from oneself or 'Derealisation' which is the experience of unreality, distance or distortion. Complete diagnosis is not met until at

least 6 months after the trauma(s), nevertheless onset of symptoms can occur immediately (American Psychiatric Association, 2013, p. 274).

Fire-fighters are at risk of experiencing PTSD, due partially to their exposure to work related trauma (Corneil et al. 1999) and can be partially due to individuals' beliefs about the world, available situational supports and coping mechanisms (Harris et al. 2002). PTSD rates among fire-fighters vary, Meyer, Zimmering, Daly, Knight, and Kamholz (2012) found a rate of current PTSD of 6.4% among experienced, professional, urban fire-fighters using a standardised clinical interview and self-report measures. Del Ben, Scotti, Chen and Fortson (2006) found 5-6%; Corneil et al. (1999) found 18-37%, this variation could be due to the wide variety of interventions utilised. One study of predictors of PTSD in trauma-exposed fire-fighters, found that fire-fighters might represent a resilient group in terms of lower-than-expected rates of PTSD (Meyer et al. 2012). Park, Kim, Baek, Yu and Choi (2010) study showed that we should be concerned in positive characteristics such as resilience to prevent posttraumatic stress symptoms.

Resilience and Growth

Emergency response work is challenging, and the situations that emergency workers encounter can have a strong impact. Such exposure to elevated levels of potentially traumatising events can have lasting negative effects such as PTSD, yet, can also have positive outcomes, such as post traumatic growth (PTG) (Armstrong, Shakespeare-Finch & Schocet, 2014). Common experiences of PTG include a changed philosophy of life; an appreciation of life; personal strength and a change in relating to others (Calhoun & Tedeschi, 2013). Tedeschi and Calhoun (1995)

pioneered the concept of PTG and maintain that some people are able to experience positive changes following a traumatic experience. Calhoun and Tedeschi, (2013) describe PTG as "an effect of deliberate and effortful reflection", subsequent to the struggle to integrate a traumatic event into shattered life narratives, rather than a direct result of the trauma itself. Armstrong et al. (2014) reinforces that PTG is a possible post trauma outcome for fire-fighters. Taking into consideration emergency workers continuous difficult working situations and repeated exposure to potentially traumatic events, efforts to promote PTG may aid individuals to see the positive benefits of the work they do (Armstrong et al. 2014). Gist (2007) advocates facilitating strength among those who rescue in their daily life, rather than a rescue based approach. Suggesting the challenge to first responder organisations is to change toward more multi-layered approaches that can assist these important organisations and their personnel to meet the demands on their increasingly complex work. PTG is an interesting theory since it suggests potentially new approaches from which to examine psychological trauma (Westphal & Bonanno, 2007). The prospect of PTG suggests hope amid the increasing threat of global terrorism and man-made disasters and supports the growing trend in social sciences towards the more positive sides of human nature (Westphal & Bonanno, 2007). A study by Regal (2010), suggests that embryonic new pointers and outcomes that are based on resilience and growth, in groups and individuals, should be developed, instead of focusing on psychopathology following exposure to traumatic incidents. Regal (2010) concludes that CISM and debriefing ought to be viewed as a type of organisational and social support, and not an intervention to thwart PTSD.

Meyer et al. (2012) study of fire-fighters found that the strongest predictor of post-traumatic stress, above and beyond coping and social support, was occupational

stress, for example the debriefers in this study felt the organisation lack sufficient communication skills. Whilst caring for their employees, workplace interventions and support programs have conventionally implemented a deprivation method (Shakespeare-Finch, 2007). This means that interventions are implemented when individual workers show signs of psychological problems, rather than incorporating a proactive attitude to creating a resilient emergency service. The Queensland Ambulance Service (QAS) is an organisation that has adapted its service employee assistance programme accordingly. The QAS now provides a peer support officer program, external professional counsellor access for staff and their families, psychosocial education in its training programs, amongst other available support (Shakespeare-Finch, & Scully, 2004). This study found high levels of satisfaction for the individual services provided in this programme. This positive, rather than negative approach is an important deliberation when considering post-incident interventions. Offering individual services, to meet individual needs, incorporating the positive aspects of trauma as well as the negatives. This concept corresponds with Jeanette and Scoboria (2008) study that recognised individual preferences. It also supports Shakespeare-Finch, Smith, Gow, Embelton, and Baird (2003) view that the experience of occupational trauma can lead to positive post-trauma transformations and Meyer et al. (2012) concept that emergency workers are a resilient group.

Trauma Response

Organisational stressors and supports have consistently shown to be major factors alleviating or intensifying traumatic stress reactions (Buunk & Peeters, 1994; Regehr, Hill & Glancy, 2000). Debriefing expresses support of the workers by management

and offers the opportunity to develop social supports within the work team (Regehr & Bober, 2005). Hawker et al. (2011) predict that appropriate psychological debriefing will be proven to have benefits for secondary victims of trauma who have been briefed together and worked together through traumatic events. They conclude that research into the use of debriefing within these scenarios should be encouraged and supported. Castro and Adler (2011) occupational model suggests an occupational-based approach to PTSD, rather than a victim-based approach, for workers in hazardous occupations and takes into account that these individuals are trained and expect to face potentially traumatic events.

Fire & Rescue Service CID Policy

The Fire & Rescue service that forms the focus of this research implemented a crisis intervention comprising of a Critical Incident Debrief (CID) Policy in 1997 (see Appendix 6). A log is kept on the number of incidents being implemented and declined (see Appendix 7).

Study Aims

Whilst being aware of past research and its numerous inconsistencies, this studies aim was to capture the lived experiences of the role of Critical Incident Debriefer within a Fire & Rescue Service in the North West of England, the results of which aim to contribute to the field of CISD within Emergency Services.

Summary of Literature Review

The study of relevant debriefing literature revealed the impact that repeated exposure to traumatic events could have on emergency workers, which can result in PTSD. As highlighted above, the research in this area has produced positive and negative outcomes or no outcome at all and further research in this area is warranted. The literature highlighted that the RCTs that concluded that debriefing did not reduce psychological distress, nor prevent the onset of PTSD, were founded on studies implementing an intervention that is extremely different from the interventions used for emergency workers. They were methodologically flawed, therefore, not accurately representative of research in this discipline. To get a deeper understanding of CISD, this study provided the Debriefers' of a Fire and Rescue Service in the North West of England, an opportunity to voice their experiences.

CHAPTER THREE

RATIONALE

CHAPTER 3

Rationale

The literature review above highlights the controversy surrounding debriefing and emergency workers. Some professionals believe that it has no benefits whatsoever; whereas others believe it is a much needed and valued support. It is widely recognised that more research in this extremely important field is urgently needed in order to identify the best way the emergency services can look after the health, safety and welfare of their employees. Although this need is recognised, to date no study could be found that investigated the experience of the role of Critical Incident Debriefers.

This study aims to gain an understanding of Fire and Rescue Service Debriefers experiences of the role of Critical Incident Debriefer. It aims to provide information to professionals and organisations, within the emergency services, in order to inform future intentions regarding psychological interventions and contribute to the gap in the literature in this area with regards to CID from a debriefer's perspective.

CHAPTER FOUR

EMPIRICAL PAPER

Journal Article

Title

An investigation of the experience of the role of Critical Incident Debriefer in a 'Fire and Rescue Service in the North West of England'

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On submission for publication, additional authors will be included as appropriate to their contribution to this research and paper

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Abstract

PURPOSE: Psychological debriefing is a crisis intervention for use with people who are exposed to stressful events within their work. Research on crisis interventions is controversial due to evidence of its benefits producing positive and negative outcomes or no outcome at all and further studies in this field are important to establish appropriate interventions for emergency workers. This study aims to qualitatively investigate the experience of the role of Critical Incident Debriefer in a Fire and Rescue Service in the North West of England.

METHODS: A phenomenological approach was used to collect data via collaborative inquiry (CI) groups with debriefers. The recorded CI group meetings were transcribed into text and transcripts analysed using applied thematic analysis.

RESULTS: Review and analysis of the participants' experiences identified a wide range of themes. The two main themes 'CID training' and 'organisational concerns' will be discussed in this article.

CONCLUSION: There is a risk that debriefers are not receiving appropriate training for facilitating psychological debriefing. The implications of this research and recommendations for future research are provided.

KEYWORDS: Fire fighters & Stress; PTSD & Fire fighters; PTSD & Emergency Services; Psychological debriefing & Fire fighters; CISD & Fire fighters.

1. Introduction

Research on disaster-induced trauma in emergency workers started emerging as early as 1980 (Dunning & Silva, 1980). Researchers have studied the impact that repeated exposure to traumatic events can have on emergency workers, recognising that it can result in stress related symptoms such as PTSD (Bryant & Harvey, 1996; Marmar, Weiss, Metzler, Delucchi, Best & Wentworth, 1999; Regehr, Hill, & Glancy, 2000; Berger, Coutinho, Figueira, Marques-Portella, Luz, Neylan & Mendlowicz, 2010). Due to the nature of their work fire-fighters may experience an elevated risk of developing PTSD (Corneil, Beaton, Murphy, Johnson & Pike, 1999; McFarlane & Bryant, 2007). Symptoms can include; guilt about surviving; feelings of detachment; depressive mood; social dysfunction; dissociation; anger and irritability; alcohol and substance misuse (Haslam & Mallon, 2003). Symptoms such as these have an impact on fire-fighters and their families (Regehr & Bober, 2005). Clinical experience and literature have produced a list of events that may cause the most distress. These events include incidents involving children; which has been reported to be the most traumatic and subsequently led to emergency workers experiencing intrusive memories (Clohessy & Ehlers, 1999); the death of a co-worker in the line of duty (Meyer, Zimering, Daly, Knight, Kamholz & Gulliver, 2012); the death of a patient in the responders care (Regehr & Bober, 2005). Other stresses can derive from organisational problems, shift work and sleep disruption (Murphy, Beaton, Pike & Johnson, 1999; Clohessy & Ehlers, 1999). One response to the symptoms fire-fighters may experience following a particular traumatising event is Critical Incident Stress Management (CISM). CISM was originally devised for US emergency medical services personnel in the early 1980s (Mitchell, 1983). Everly, Flannery and Eyler, (2002) depict the complete CISM crisis intervention system as one that employs a multi-component programme, consisting of; small group crisis interventions (CISD, defusing); large group crisis interventions (demobilizations, crisis management briefings, town meetings); individual crisis counselling (face to face,

telephonic); family crisis intervention, and mechanisms for follow up and referral for formal assessment and or psychotherapy. Additionally, it aids the early detection and treatment of post-trauma responses and other psychological sequelae (Regal, 2007). Controversy occurred when interest was focused on CISD, one element of CISM. This one element became the focus for research due to it being inaccurately believed that this particular element of the model would prevent the development of PTSD per se, and was a standalone procedure (Regal, 2007).

CISD is a supportive crisis intervention process, created for groups of emergency service personnel and disaster workers following critical incidents (Mitchell, 1983; Dyregrov, 1989; Mitchell & Everly, 1997). A critical incident is an unexpected event, or series of events and circumstances, that may result in adverse consequences (Woloshynowych, Rogers, Taylor-Adams & Vincent, 2005). CISD was distributed as a programme "designed by an emergency person for emergency people" (Mitchell & Bray, 1990, p. 89). It is not psychotherapy, nor a substitute for psychotherapy. It aims to inform and empower by normalising common reactions to trauma and providing information regarding coping strategies and further support if needed (Mitchell, 1983).

PTSD rates among fire-fighters vary, Meyer et al. (2012) found a rate of current PTSD of 6.4% among experienced, professional, urban fire-fighters using a standardised clinical interview and self-report measures. Del Ben, Scotti, Chen and Fortson (2006) found 5-6%; Corneil et al (1999) found 18-37%, this variation could be due to the wide variety of interventions utilised. One study of predictors of PTSD in trauma-exposed fire-fighters, found that fire-fighters may represent a resilient group in terms of lower-than-expected rates of PTSD (Meyer et al. 2012). Park, Kim, Baek, Yu and Choi (2010) study showed that we

should be concerned with positive characteristics such as resilience and high self-esteem to prevent posttraumatic stress symptoms.

Emergency response work is challenging, and the situations that emergency workers encounter can have a strong impact. Such exposure to elevated levels of potentially traumatising events can have lasting negative effects such as PTSD, yet, can also have positive outcomes, such as post traumatic growth (PTG) (Armstrong, Shakespeare-Finch & Schocet, 2014). PTG is an interesting theory since it suggests potentially new approaches from which to examine psychological trauma (Westphal & Bonanno, 2007). The prospect of PTG suggests hope amid the increasing threat of global terrorism and man-made disasters and supports the growing trend in social sciences towards the more positive sides of human nature (Westphal & Bonanno, 2007). Regal (2010) study suggests that embryonic new pointers and outcomes that are based on resilience and growth, in groups and individuals, should be developed. Instead of focusing on psychopathology following exposure to traumatic incidents, be mindful of growth. Regal (2010) concludes that CISM and debriefing ought to be viewed as a type of organisational and social support, and not an intervention to thwart PTSD. Gist (2007) advocates facilitating strength among those who rescue in their daily life, rather than a rescue based approach, suggesting the challenge to first responder organisations is to change toward more multi-layered approaches that can assist these important organisations and their personnel to meet the demands on their increasingly complex work.

Meyer et al. (2012) study of fire-fighters found that the strongest predictor of post traumatic stress, above and beyond coping and social support, was occupational stress. Owing to the comparatively high level of exposure to trauma and potential stress in the workforce, emergency service organisations such as, fire, police, ambulance and the military, understand the need for a resilient workforce (Shakespeare-Finch, 2007). However, whilst caring for

their employees, workplace interventions and support programs have conventionally implemented a deprivation method (Shakespeare-Finch, 2007). This means that interventions are implemented when individual workers show signs of psychological problems, rather than incorporating a proactive attitude to creating a resilient emergency service. The Queensland Ambulance Service (QAS) is an organisation that has adapted its service employee assistance programme accordingly. The QAS now provides a peer support officer program, external professional counsellor access for staff and their families, psychosocial education in its training programs, amongst other available support (Shakespeare-Finch & Scully, 2004). This study found high levels of satisfaction for the individual services provided in this programme. This positive rather than negative approach is an important deliberation when considering post-incident interventions. Offering individual services, to meet individual needs, incorporating the positive aspects of trauma as well as the negatives. This concept corresponds with Jeanette and Scoboria (2008) study that recognised individual preferences. It also supports Shakespeare-Finch, Smith, Gow, Embelton, and Baird (2003) view that the experience of occupational trauma can lead to positive post-trauma transformations and Meyer et al. (2012) concept that emergency workers are a resilient group.

Organisational stressors and supports have been consistently shown to be major factors alleviating or intensifying traumatic stress reactions (Buunk & Peeters, 1994; Regehr et al. 2000). Debriefing expresses support of the workers by management and offers the opportunity to develop social supports within the work team (Regehr & Bober, 2005). Hawker, Durking and Hawker (2011) predict that appropriate psychological debriefing will be proven to have benefits for secondary victims of trauma who have been briefed together and worked together through traumatic events. They conclude that research into the use of debriefing within these scenarios should be encouraged and supported. Tuckey and Scott (2014) see value in changing the focus of future research away from whether or not a

particular method can thwart the manifestation of clinical symptoms, to focus instead on understanding why and how early intervention in occupational settings works to encourage recovery from operational stressors, taking into account individual, group and organisational processes and aspects. Castro and Adler (2011) occupational model, suggests an occupational-based approach to PTSD, rather than a victim-based approach, for workers in hazardous occupations. The Occupational approach takes into account that these individuals are trained and expect to face potentially traumatic events; they can continually be exposed to traumatic experiences; the social context of working in teams and treatment approaches that take into account the occupational context, so that symptoms are addressed as part of a larger response to this kind of work, rather than a specific response to a traumatic event.

Awareness of CISD with regards to fire-fighters has developed over recent years. Some researchers report that debriefing protects fire-fighters from stress related disorders, such as PTSD, encouraging its need and success (Robinson & Mitchell, 1993). Others believe it has no benefits and should cease (Rose, Bisson, Churchill, & Wessley, 2002). The Cochrane Review (Rose et al. 2002) recognised that there was a lack of appropriate training for those facilitating psychological debriefing. Little faith in the competence of debriefers was also expressed in Durkin and Bekerian (2000) study on psychological resilience to stress in fire-fighters with the Home Office (2000) report 'Fit for Duty?' warning of the cost of a well-intended but unskilled intervention (p. 73, 21-25). However, Wagner (2005) after reviewing all the available literature regarding the effectiveness of CISD for use with emergency service workers, concludes that for this population, the call for the removal of current programmes using CISD to be unwarranted. This view is supported by Kinchin (2007) who advocates that throughout the early part of the twenty-first century a 'myth' was established that early intervention was of little or no assistance and may actually do harm. However, this was a striking difference of opinion to that of the needs expressed by traumatised people. While this

myth, with its ensuing debate, may assist with critically reviewing the early responses, which aid people following traumatic incidents, there is also a grave danger of rejecting the essential along with the inessential (Dyregrov, 2003). It appears that the main reason for the recommendations to cease debriefing is the primary principal medical ethics of 'do no harm' (Hawker et al. 2011). Nevertheless, one has to consider the harm done by withdrawing an intervention from occupational groups who have been relying on it to help them cope with working in extremely difficult circumstances, for over 20 years (Hawker et al. 2011).

The Fire & Rescue service that forms the focus of this research implemented a crisis intervention comprising of a Critical Incident Debrief (CID) Policy in 1997, updated in 2012. The aim of the policy is to reduce the emotional and psychological after effects that maybe experienced by staff following traumatic incidents, by instigating early supportive interventions. It is implemented as 'effective trauma management' and has three critical stages; defusing; critical incident stress debrief and post debrief (Fire & Rescue Service CID Policy, 2012).

2. Study Aims

Whilst being aware of past research and its numerous inconsistencies in its findings, this studies aim was to capture the lived experiences of the fire service personnel who implement the policy, the 'debriefers', to gain primary data for analysis. This study was approached from a phenomenological viewpoint, which seeks to provide a description of lived experiences, perceptions and emotions (Bray, Lee, Smith & Yorks, 2000). This was achieved via 'Collaborative Inquiry (CI) Groups' with the 'debriefers'. CI Groups invite individuals with the same interest, to be co-researchers in a study, to gain experience and knowledge from those involved, which provides valuable qualitative data. The qualitative data was analysed via Thematic Analysis, the results of which aim to contribute to the field of CISD within

Emergency Services and inform best practice with regards to debriefing within a Fire & Rescue Service.

3. Methods

3.1. *Design.*

A qualitative phenomenological design was employed in this study. A phenomenological approach is applied in qualitative research to describe peoples' experiences of specific phenomena in an attempt to get to the truth of matters, to depict *phenomena*, in the widest sense as whatever appears in the manner in which it appears, that is as it expresses itself to consciousness, to the experiencer (Moran, 2000). Phenomenology requires evasion of all misconstructions and impositions assigned on experience in advance, whether these are elicited from religious or cultural traditions, from daily common sense, or, indeed, from science itself, explanations are not to be executed prior to the phenomena being understood from within (Moran, 2000).

Ethical approval was acquired from the University of Chester Department of Social Studies and Counselling Research Ethics Committee and a letter of approval was received. After a presentation to the Fire Service Consultation, Research and Assurance Group (CRAG) by the principle researcher, permission was granted to conduct the research.

3.2. Participants

The occupational setting for this study was a Fire and Rescue Service in the North West of England. All 21 debriefers were invited to attend a presentation by the principle researcher inviting them to participate in the research. 38% attended, of which 75% responded. The study participants consisted of six debriefers (two female non-operational debriefers and four

male operational debriefers). They had a mean age of 47 and 20.33 years of experience in the fire service.

3.3 Data Collection

Data collection was obtained via five CI Group meetings, which were recorded. CI was identified as being an appropriate method, as CI builds on lived experience, not second-hand experience (Bray, Lee, Smith & Yorks, 2000). This kind of research works with people rather than on people (Denscombe, 2010). CI was carried out in accordance with Bray et al. (2000) direction, beginning with a structured guidance on how the groups would operate. It enabled the Debriefers to develop their own ideas and work together in a collaborative group to address matters of importance. All involved worked together as co-researchers, allowing for involvement in the design and management of the study. Everyone was involved in drawing conclusions and influencing the process (Denscombe, 2010). The CI meetings lasted on average one hour and eight minutes and were held in local fire station community rooms, which participants selected, as they felt this venue would provide the necessary privacy.

3.4 Analysis

The recorded CI Group meetings were transcribed verbatim by the principle researcher and qualitatively analysed using Thematic Analysis utilising guidelines from Braun and Clarke (2006) and Guest, MacQueen and Namey (2012). An overall model of Applied Thematic Analysis (ATA) was utilised as it is a combination of grounded theory; positivism; interpretivism, and phenomenology, merged to make one methodological framework, following the guidelines of Guest et al. (2012). Using the ATA approach enabled a rigorous, nevertheless inductive, set of procedures to be followed, devised to identify and examine themes from textual data in a manner that is transparent and credible. Drawing from a broad range of several theoretical and methodological perspectives this methods primary concern

stands with organising the experiences voiced by participants as accurately and comprehensively as possible (Guest et al. 2012). NVivo Mac is a qualitative data analysis computer software package which was used to assist with organising data and represented Braun and Clarke (2006) description of the six phases of thematic analysis; familiarising with the data; generating initial codes; searching for themes; reviewing themes, defining and naming themes and producing the results, which ultimately resulted in six parent themes. To validate the credibility of the data, the participants reviewed the six parent themes and feedback was requested, until general unanimity was reached.

4. Results

The analysis of the data identified six themes; policy concerns, organisational concerns, CID training, psycho-education, culture and the future of CID, of which all participants were in agreement. Two main themes: CID training and organisational concerns will be discussed in this journal article, whilst the remaining results are discussed in greater detail in the thesis by Haynes (2015).

4.1 CID Training

Debriefers feel they lack sufficient training:

> "*...I can't remember whether it gets said because it's your erm personal view or whether it's been said because that's what we've been taught..." (CI-5-Line-815).*
>
> *"We've never had any refresher re-training..."(CI-5-Line-841).*

"...that might be a an example of why we need it... cause we can't remember what we've been told and whether its personal view..." (CI-5-Lines-843/847).

Debriefers spoke of the lack of mental health training:

"...I don't think as an organisation as well we kind of erm educate people... it's only kind of recently that we've like done some of the mental health training..." (CI-5-Line 680).

"It's probably come a bit more forefront but in the past we've not really addressed with management how do you see how do you visualise or how do you recognise someone is stressed. We've never really kind of supported line managers to do that." (CI-5-Line-682).

"Just cause the organisation gives you a couple of hours on mental health training doesn't mean anything really does it." (CI-5-Line-729).

Participants expressed concern about the quality of the training:

'how do we know what we're doing is right?' (CI-3-Line-362).

'...all he said is his own opinion off his experience our experience is that this works why who says his way is better.' (CI-3-Line-1767)

Debriefers recognised that explaining signs and symptoms of stress is helpful, but do not feel adequately trained:

> "*I don't think I know enough about it. All I know is that what you know I think by outlining what could happen if it was personal." (CI-4-Line-1177).*

> *"... I kind of don't really go too much in to that kind of detail as recognising the symptoms." (CI-4-Line-1201).*

> *"I don't know I can't recall any training..." (CI-5-Line-805).*

Debriefers feel unsupported within their role:

> "*… it's alright saying err (.) ya know we're down there in that low priority and training there's not much we can do about it. I think we should push it..." (CI-3-Line-164).*

> *"...I think we do need some kind off loading process." (CI-3-Line-553).*

> *"...regarding our own welfare or training I think we're just forgot about..." (CI-3-Line-686).*

> *"...there's almost no backup..." (CI-5-Line-2896).*

4.2 Organisational Concerns

Improvements are recognised within the CID process with people having a clearer understanding of mental health and PTSD, however debriefers feel there are still significant concerns:

> *"... It's taken a long time to get where we are with these and I still don't think we're where we should be but the difference between 97 and now is massive." (CI-1-Line-410).*

> *"People probably know what PTSD stands for now whereas years ago PTSD its just another acronym..." (CI-2-Line-2609).*

> *"People know what it actually means. So that's a start in itself." (CI-2-Line-2618).*

Debriefers discussed the fear around presenting with mental health issues:

> *"...they'll hide it because they feel ashamed...You know men more so." (CI-1-Lines-2652/2654).*

> *"So if somebody with stress or who's not feeling right gonna put their hand up and say can somebody help me... or am I gonna be looked at as capable of doing the job." (CI-4-Line-1409).*

> *"Oh the DREADFUL fear out there of this absence management and capability. " (CI-4-Line-1417).*

Debriefers discussed suicides within the organisation:

> *"... but I mean last year how many suicides did we have." (CI-1-Line-2759).*

> *'We had three last year was it three four?' (CI-1-Line-2774).*

> *"... four within a matter of about 18 months." (CI-1-Line-2778).*

> *"I think there's more. There's someone who just retired topped himself as well so I'm sure it's more than four." (CI-5-Line-2426).*

Preparing emergency workers for the trauma they will most likely face could help them become more resilient:

> *"...getting more err focused on preparing them for when it does happen making them more resilient..." (CI-1-Line-2136).*

> *"...making it explicit sort of signs and symptoms of stress" (CI-5-Line-792).*

> *"...by saying...some of these symptoms have been identified as...symptoms of stress..." (CI-5-Line-794).*

5. Discussion

This study explored the lived experiences of fire service personnel who implement the CID policy, the 'debriefers' and their perceptions to gain an insight into how the 'debriefers' perceive the CID Process. The experiences of the debriefers were examined using a

qualitative approach, from a phenomenological stance via CI groups. CI provided an opportunity for the researcher to achieve a comprehensive understanding of debriefers experiences, which enabled consistent themes throughout each CI group meeting to be identified. These findings offer valued insights and recognise further research opportunities for the emergency services when investigating CISD.

The debriefers are dedicated and passionate within this arena, however, they have concerns regarding the lack of appropriate training and support, having had very little, if any, refresher training or debriefer meetings, which they feel reflects how the organisation view CID and makes them feel *'undervalued' (CI-2-Line-2327).* Debriefers agreed that training and implementing a support mechanism where they can get together as a group and share *'experiences' (CI-3-Line-366)* would be beneficial *(CI-1-Line-1008).* Debriefers feel they have no leadership and described it as *'a rudderless ship' (CI-3-Line-175)* and felt it important that the lack of training was raised in this research. Debriefers discussed how they cannot remember what they have been *'taught' (CI-5-Line-821)* and what is personal opinion. This raises an important issue as to whether debriefers are appropriately trained and corresponds with the findings of the Cochrane Review (Rose et al. 2002) which recognised a lack of appropriate training for those facilitating psychological debriefing. Debriefers feel that giving information on *'signs and symptoms of stress' (CI-5-Line-792)* would be beneficial and can help people recognise them. They do not recall being taught stress symptoms *(CI-5-Line-805),* although they are unsure if that is due to a lack of refresher training *(CI-5-Line-835).*

Debriefers expressed concern regarding what they have been taught and question *'how do we know what we're doing is right?' (CI-3-Line-362).* The CI group had a mutual conceded desire to help people and this was a strong commonality within the group, however, they question guidelines feeling their *'experiences' (CI-3-Line-1768)* tell them differently. This

uncertainty towards training highlights an area for further investigation and corroborates Durkin and Bekerian (2000) study which expressed little confidence in the relevant expertise of debriefers and the Home Office (2000) report 'Fit for Duty?' cautioning against a well-intended but uneducated intervention (p. 73, 21.25).

Debriefers feel they are *'left alone to do what they think is best' (CI-5-Line-2888)* and have almost *'no backup' (CI-5-Line-2896)* or *'support' (CI-5-Line-2900).* This raises an important issue with regards to debriefer welfare and as they often hold dual roles as fire-fighters conveys Corneil et al. (1999) findings that fire-fighters are at risk of experiencing PTSD, due partially to their exposure to work related trauma and Harris, Baloglu and Stacks (2002) which identifies PTSD can be partially due to individuals' beliefs about the world, available situational supports and coping mechanisms. So as to address this issue, organisations could ensure debriefers have appropriate support mechanisms in place.

Debriefers feel there have been improvements since the introduction of CID's, with CID becoming more accepted due to a clearer understanding of mental health and PTSD *(CI-2-Line-2609),* however, believe there are unresolved significant concerns. Debriefers described a *'dreadful fear' (CI-4-Line-1417)* regarding people presenting with mental health issues as it was thought the organisation might judge people with regards to their capability to do their job *(CI-4-Line-1423).* Suicides within the organisation is a serious concern, debriefers discussed how there were three or four suicides within one eighteen-month period *(CI-1-Line-2778)* one debriefer thought there was more than four *(CI-5-Line-2426).* Pro-active interventions, rather than victim based approaches were deliberated and how educating fire-fighters on the effects of trauma and coping strategies, in preparation for them attending traumatic events, could help them become more resilient. The group spoke of the importance of recruit training regarding *'what the job entails' (CI-1-Line-1451)* and *'support mechanisms'*

(CI-1-Line-1452) so that they can learn coping strategies and *'build resilience' (CI-1-Line-2242)*. Providing 'Psycho-education', being taught what to expect and being equipped with coping mechanisms promotes resilience. This is consistent with previous research that suggests emergent new indicators and outcomes that are founded on resilience and growth, in groups and individuals, should be formed, instead of concentrating on psychopathology following exposure to traumatic incidents (Regal, 2010). This could help emergency workers see the benefits in the work they do (Armstrong et al. 2014). Debriefers felt that setting up pro-active interventions, like the Ambulance Service documented in the Literature Review (Shakespeare-Finch & Scully, 2004) would have to be justified and proven to be cost effective. This highlights the need for further research with regards to suitable interventions.

5.1 Limitations

The small sample size could be viewed as a limitation of the study, with the findings being indicative of the experiences of this particular group of debriefers, therefore should be considered cautiously. CI does however consider somewhere between five and 12 to be the number that allows for diversity, while still allowing the group to function democratically and with reasonable efficiency (Bray et al. 2000) and provided an opportunity for the researcher to achieve a comprehensive understanding of the debriefers experiences, which identified consistent themes throughout the CI group meetings.

Secondly, CI Groups were identified as being an appropriate method, however, due to the nature of the organisation, group members were unable to commit to every CI meeting. This was due to debriefers holding dual roles, such as fire-fighters, who could not attend all meetings due to shift changes or industrial action. This is not typical of CI, as all members of

a CI group would ordinarily commit to attending all meetings and this could have affected the meetings content, therefore the interpretation of the results should be considered cautiously.

Whilst the findings of this study offer a valuable insight into the role of CID within a Fire and Rescue Service and are a reliable and valid snapshot of this group at this time, other debriefers will have their own individual experiences guided by different policies and Fire and Rescue Services.

5.2 Implications

The principle researcher identified and acknowledged how the inclusion of 'pro-active interventions' in the literature review could have influenced this research.

Debriefers felt it was essential to get the views of the 'debriefees' in order to get a true picture of CID within the organisation. Future research directed at debriefees experiences of CID would extend these findings and should be considered.

6. Conclusions

The study identified that there has been improvements since the introduction of CID, with people having a clearer understanding of mental health and PTSD. The findings however, lend support for previous research that highlights concerns within CISD, such as the Cochrane Review (Rose et al. 2002) which recognised a lack of appropriate training for those facilitating psychological debriefing and Durkin and Bekerian (2000) study which expressed little confidence in the relevant expertise of debriefers and the Home Office (2000) report ‘Fit for Duty?’ cautioning against a well-intended but uneducated intervention (p. 73, 21.25). The training incorporated within this policy does not appear to inform and empower by

normalising common reactions to trauma and provide information regarding coping strategies as directed by Mitchell (1983). The findings identified concerns with regards to the number of suicides within the organisation. Appropriate training to build resilience was considered as beneficial, to help people become more resilient, instead of concentrating on psychopathology. Additionally pro-active Interventions were highlighted but further research was suggested in order to confirm their validity.

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CHAPTER FIVE

EXTENDED

DISCUSSION

CHAPTER 5

Discussion

This chapter will give a summary of the results found in relation to the intended aims of this study specified in Chapter 1, page 2, and will relate the findings to the wider literature. This is an extended version of the results section incorporated in the journal article in Chapter 3. Methodological considerations will be discussed including limitations and implications for future research. Ethical considerations and confidentiality will follow, ending with a reflexive statement to make my own opinions, thoughts and feelings visible.

5. Summary of Results

This study explored the lived experiences of the role of Critical Incident Debriefer in a Fire and Rescue Station in the North West of England. Experiences were examined using a qualitative approach, from a phenomenological stance via Collaborative Inquiry (CI) groups. CI provided an opportunity for the principle researcher to achieve a comprehensive understanding of debriefers experiences which enabled consistent themes throughout each CI meeting to be identified. These findings offer valuable insights and recognise further research opportunities for the emergency services when investigating CISD.

The analysis of the data identified 6 themes; policy concerns, organisational concerns, CID training, psycho-education, culture, the future of CID, of which all participants were in agreement.

5.1 Policy Concerns

Debriefers confirmed that improvements have been made within the organisation towards CID and referred to it as *'an institutional development' (CI-1-Line-773).* Positive attitudes are emerging, such as fire-fighters recognising symptoms in crews and requesting CIDs *"...a fireman that had noticed change in his workmates...I mean that was just superb…" (CI-2-Line-2429)* however, there was a general consensus that there isn't a clear understanding of CIDs and the policy is perceived as having unclear direction *"I still don't think it's clear (.) I think it's still very iffy and I think it just it all depends on who is saying do you want one..."(CI-1-Line-417).* Debriefers believe the way in which CIDs are approached is crucial and a lot depends on officers' attitudes *"Right lads you're alright you don't want one of them you don't need one of these do ya?*" *(CI-1-Line-737).* Describing some within the organisation as having unconstructive views *"still till this day I speak to people who are dead against it... (CI-1-Line-790),* reminiscent of out-dated terms that Kinchen (2007) refers to, such as *lack of morale fibre.* One debriefer described having many discussions around these attitudes and although he *"fundamentally disagrees" (CI-1-Line-792);* he believes that there are still individuals within the organisation who make decisions based around these views *(CI-1-Line-793).*

Certain criteria were felt to be *"almost extremes" (CI-5-Line-1291)* that are *"on the fringe of everything"* whilst *"day to day stuff" (CI-5-Line-1293)* is not recognised. This corresponds with Regehr and Bober (2005) findings that fire-fighters are more commonly exposed to smaller scale traumatic events such as road traffic accidents or suicides and Marmar et al. (1996) findings that found the impact of small-scale incidents on emergency workers was equivalent to that of larger scale events.

Debriefers felt that CIDs should be instigated by anyone *"I think it should be at discretion... of anyone." (CI-5-Line-1326).* One debriefer suggested a certain amount of exposure, within a certain timeframe, should instigate an intervention *" if you're exposed to so many in a certain length of time maybe that would instigate..."* [interventions] *(CI-5-Line-1338).* It was thought that attitudes also depend on experience, e.g. Ex-forces personnel are more receptive towards CID having experienced interventions such as TRiM "...*because they've been in the forces they're used to it." (CI-2-Line-2574).*

It was felt the organisation did not follow the policy when a fire-fighter tragically lost his life fighting a fire, as they employed an outside agency to implement the CID. *"They completely went against the policy didn't they...there was no policy on that day basically." (CI-1-Line-544).* It was recognised that this incident was still under investigation and therefore a tentative subject *(CI-1-Line-1523).* The majority of debriefers felt undervalued and undermined that the organisation didn't trust them to deal with this incident *"... when there's a proper fatal... ya know you've been playing at it. This is proper one so you can't come and do it." (CI-3-Line-940).* It was recognised there may not be enough 'in-house' debriefers to cover such a case, however, it was considered important for future reference that something is implemented, such as using a neighbouring Brigade who implement a similar policy, to increase the number of debriefers, rather than using external companies *(CI-2-Line-1831).* The principle researcher contacted all Fire & Rescue Services in England to enquire if they have a CID Policy in place (please see Appendix 11 & 12). The nearest Brigade has a CID policy and already interlinks.

Debriefers feel like CID is leaderless *"We've kind of got a rudderless ship haven't we." (CI-3-Line-175).* Debriefers' described morale *as 'couldn't get any lower' (CI-4-Line-287)* and described how their role as debriefers affects them *"The incidents I go to I can't remember half of them...what I've attended, but I remember all these debriefs... and they're in me head..." (CI-3-Line-441)."... I think my own way of coping I put it away somewhere else...but all these debriefs its as though I attended." (CI-3-Line-445).* One debriefer wondered if any research has been carried out with regards to the affect CID can have on debriefers *(CI-3-Line-470).* Debriefers feel that they give their time for free *"...we're not paid to do it" (CI-3-Line-724)* yet feel undervalued *"...I don't feel valued doing this." (CI-3-Line-367)*. They feel they are running CID themselves with *"no back-up" (CI-5-Line-2896)* and question the validity of the training. This raises an important issue with regards to debriefer welfare as appropriate support mechanisms for debriefers are not evident, which is concerning and supports findings that organisational stressors and supports have consistently shown to be major factors alleviating or intensifying traumatic stress reactions (Buunk & Peeters, 1994; Corneil et al. (1999); Harris et al. (2002); Regehr et al. (2000).

Debriefers feel Emergency Fire Crews (EFCs) should be incorporated into the CID Policy. EFCs are partially trained and provide cover during a strike period. Debriefers doubt that EFCs are aware of CIDs and feel that they would particularly benefit from them as they lack experience, receive minimum training, don't have the support of a watch and can face animosity as they are *'breaking a strike.' (CI-3-Line-1881).* It was felt that EFCs are an important issue that should be raised now with regards to health and safety and protecting the workforce.

The Technical Rescue Unit (TRU) was described by debriefers as *'an emergency salvage tender that goes to where people are trapped' (CI-5-Line-1778),* and are of a serious nature. One debriefer works on the TRU and described his experience: *"I've had 3 in the last 3 weeks...and I've had nothing different cause...it didn't meet anything... currently however I've just been exposed to a lot more and that's gonna keep on happening." (CI-5-Lines-1556/1560/1565).* The TRU are dealing with bigger more severe incidents across many station areas and the personnel are subjected to repeated trauma, yet are not monitored. TRU crews are subject to more fatal incidents, which don't necessarily qualify as requiring a CID and frequency is not taken into consideration. *'TRiM' (CI-5-Line-1566)* was discussed as a possible solution. It was suggested that *'might be a role for the station managers' (CI-5-Line-1673)* to monitor trauma expose and *'get something in place that feeds back in that'll then trigger...* [interventions] *'(CI-5-Line-1676).*

Control, Flexi Duty Officers and Fire and Investigation are rarely present at a CID, although it is thought *"...they're the ones that maybe need it the most..." (CI-1-Line-1615)* as they have not got the support of a watch.

Debriefers do not recall being invited to have an input in policy updates and believe this to be *'logical' (CI-2-Line-2779)* as they could provide an informed input *(CI-2-Line-2750).* It was recognised how implementing new procedures costs money and requires evidence-based research *"Until organisations can see that there's a cost saving here to be made there're never going to put the money up front..." (CI-1-Line-2737).*

5.2 Organisational Concerns

Debriefers described a lack of *"trust" (CI-2-Line-2066)* within the organisation, explaining how people are cautious when involved in anything they perceive could *"report back" (CI-2-Line-2072)* to the organisation. Debriefers acknowledge that line managers need support and training, but it was felt the organisation do not prioritise mental health and *"a couple of hours on mental health" (CI-5-Line-729)* is not enough.

Debriefers feel people are too afraid to have time off with stress, preventing them from asking for help, one debriefer describing it as a *"DREADFUL fear." (CI-4-Line-1417) "...I didn't take any time off because you're frightened to death."' (CI-4-Line-1400)*. *"There are people off with cancers and really bad illnesses and their still being looked at as capable and absence management..." (CI-4-Line-1407).*

The group discussed fire-fighters taking their own lives and the amount of recent suicides within the brigade within one 18 month period *"...four within a matter of about 18 months." (CI-1-Line-2778).* This was described as *"horrendous" (CI-1-Line-2770).* One debriefer thought there could have been more than four suicides *"There's someone who just retired topped himself as well so I'm sure it's more than four." (CI-5-Line-2426).* The principle researcher contacted local coroners offices to confirm statistics, however was unsuccessful as not all could provide the required data. Sadly another fire-fighter was discovered hanged in the grounds of a fire station towards the end of this research (Keeling, 2015).

Debriefers explained how people are unaware of available support. One debriefer explained how a questionnaire looking at *'how aware personnel are of support within the organisation'* produced poor results *"I thought that levels of knowledge would be low but they were virtually non-existent." (CI-1-Line-1461).* The Employee Assistance Program provider PPC Worldwide has been in contract since February 2012. The services are available to all employees and their immediate family 24 hours a day, 365 days a year. These services include: Telephone Counselling; Face To Face Counselling; Online CBT; Financial and Legal advice; Advice on family and domestic matters; Management Consultation and advice (Fire & Rescue Authority Policy Resources and Performance Committee, 2014). Debriefers felt there's *"not much awareness of what PPC is (.) how to access it…" (CI-2-Line-2627)*. It was felt that communication has now deteriorated and the organisation need to get back to basic communication *"It's the story of this organisation and lots of organisations...communication is rubbish." (CI-4-Line-245).* Debriefers discussed how information gets put on the website and *"...no one sees it.*" *(CI-4-Line-217).*

Debriefers feel there is a general mistrust within the organisation *"...There is a general mistrust full stop." (CI-2-Line-2098).* People do not want to speak out for fear of being judged and do not want to be seen as *"criticising" (CI-2-Line-2139)* higher ranks. Debriefers feel if senior managers attend a CID there can be reluctance to participate for "fear of confidentiality" *(CI-4-Line-53).* The willingness of fire-fighters to participate in debriefings is *'very mixed' (CI-4-Line-35)* but becoming *'more positive' (CI-4-Line-130)* and group dynamics within CIDs have improved with only *'the odd few now that'll disrupt it...' (CI-5-Line-225).* Debriefers recognise different campaigns; smoke alarms and fire prevention within the *"community" (CI-1-Line-2190)* has more publicity nowadays, thus there has been a reduction in fires, which

unfortunately takes away fire-fighters experiences and puts them in a weaker position, as they are not becoming normalised to trauma therefore *"they need training to be able to cope with that when it does happen so that they build resilience" (CI-1-Line-2241).*

Different emotions emerge in a CID including anger, which tends to be directed more to other emergency services rather than the fire service *"The anger tends to be not at us the anger usually is based on ambulance service or police." (CI-4-Line-1888). "...It's always been 'we weren't able to do this.' or 'they didn't come quick enough.' or 'they were in the way.' or 'members of the public taking photographs." (CI-4-Line-1895).* Fire-fighters rarely get upset with each other in a CID *"...the majority of fire-fighters don't have a pop at other fire-fighters while they're in a debrief..." (CI-5 Line-1165).* This is thought to be due to a lack of trust in confidentiality: *"I know people who have had a word with somebody out of a debrief but they're reluctant to sort of point the finger of blame at somebody in something that's still seen as an official sort of gathering." (CI-5-Line-1169).* Debriefers explained that a lot of questions fire-fighters have relate to other emergency services. If these services were given the opportunity to explain their actions it could reassure people *"Oh well thank goodness for that now I know why he did it, that makes me feel better" (CI-2-Line-1166).* Joint Emergency Service Interoperability Programme (JESIP) [see the following link for details: http://www.jesip.org.uk/#] has been established by the Home Office and has the full support of the Professional Associations that represent each of the blue light emergency services. It relates to the fire service, ambulance and police working together, to improve communication, information sharing and mobilisation procedures between services. Although debriefers cannot imagine all the blue light services collaborating, they do believe it would be *"ideal" (CI-3-Line-2079).*

5.3 CID Training

Debriefers feel that they lack sufficient training, in particular refresher training: *"We've never had any refresher train re-training...that might be a an example of why we need it... cause we can't remember what we've been told and whether its personal view..." (CI-5-Line-841).*

Debriefers expressed concern regarding the validity of the training feeling their experiences tell them differently *"...all he said is his own opinion off his experience our experience is that this works why who says his way is better..." (CI-3-Line-1767).* This uncertainty towards training highlights an area for further investigation and corroborates Durkin and Bekerian (2000) study which expressed little confidence in the relevant expertise of debriefers and the Home Office (2000) report 'Fit for Duty?' cautioning against a well-intended but uneducated intervention (p. 73, 21-25). Debriefers are committed and recognise that being educated in trauma and what to expect can help people, however, do not appear to have adequate training. This raises an important issue as to whether debriefers are suitably trained and corresponds with the findings of the Cochrane Review (Rose et al. 2002) which recognised that there was a lack of appropriate training for those facilitating psychological debriefing.

5.4 Psycho-Education

Debriefers believe employees diagnosed with PTSD would pursue a claim *"...if you did have Post Traumatic Stress your gonna put a claim in against the Brigade cause they've caused it." (CI-1-Line-2107).* Debriefers debated how CID impacts on PTSD

and agree CID is a positive process; however, they do not know the effect the policy has on PTSD *"We don't know." (CI-2-Line-189).* Debriefers recognise that there is much more awareness around PTSD now *"People know what it actually means" (CI-2-Line-2618)* however, they feel they do not have enough training regarding the symptoms of trauma. *"I don't know I can't recall any training..." (CI-5-Line-805).*

The group agreed providing *'Psycho-education' (CI-1-Line-2134)* to all employees when they join the fire service would be advantageous. This is consistent with previous research that suggests emergent new indicators and outcomes that are founded on resilience and growth, in groups and individuals should be formed, instead of concentrating on psychopathology following exposure to traumatic incidents (Regal, 2010). This could help emergency workers see the benefits in the work they do (Armstrong et al. 2014).

5.5 Culture

Debriefers emphasised the importance of recruits being taught about watch culture and how humour is used as a coping mechanism *"...even more so now because everybody is so politically correct."(CI-1-Line-2319).*

The group identified that there is still a stigma attached to stress *"...they'll hide it because they feel ashamed...You know men more so." (CI-1-Lines-2652/2654)* and the fire service has a culture of a predominantly male workforce. It was felt that peer pressure does exist and someone saying *'Right lads you're alright you don't want one of them you don't need one of these do ya?' (CI-1-Line-737)* can pressure people into keeping quiet about their concerns. Debriefers felt people are afraid of admitting they are suffering *"I should be able to cope with this...other people are going through*

hell and this is nothing and I'm just not sleeping..." (CI-1-Line-2660). The group agreed that comments, especially from older generations, such as *'you've just got to get on with it' (CI-1-Line-2664)* keep the stigma alive.

5.6 The future of CID

Improvements are recognised within the CID process and debriefers feel it has developed significantly since its introduction in 1997*"...the difference between 97 and now is massive." (CI-1-Line-411).* It was recognised that preparing emergency workers for trauma they will most likely face will help them become more resilient and could be beneficial to all *"...getting more err focused on preparing them for when it does happen making them more resilient..." (CI-1-Line-2136).* Pro-active interventions, rather than victim based approaches were deliberated. Debriefers felt that setting up a pro-active intervention, like the Ambulance Service in Australia documented in the Literature Review (Shakespeare-Finch & Scully, 2004) would have to be justified and proven to be cost effective *(CI-1-Line-2747).* This highlights the need for further research with regards to suitable interventions.

Methodological Considerations

This section will discuss participants, the consent process and methods. It will examine implications and limitations, future research considerations, ethical considerations and confidentiality.

Participants

After a presentation (see attached Powerpoint file) to the Fire Service Consultation, Research and Assurance Group (CRAG) by the principle researcher, permission was granted to conduct the research. All 21 Critical Incident Debriefers were invited to a presentation (see attached Powerpoint file and Appendix 1) by the principle researcher inviting them to participate in the research. 38% attended, of which 75% responded. The study participants consisted of six debriefers (two female non-operational debriefers and four male operational debriefers). They had a mean age of 47 and 20.33 years of experience in the fire service.

Consent Process

Consent was sought via completing consent forms (see appendix 2), which were distributed to participants during the initial presentation. Stamped address envelopes were included to return the consent forms to the principle researcher.

Methods

A qualitative phenomenological design was employed in this study and data collection was obtained via five Collaborative Inquiry (CI) Group meetings, which were recorded. CI was carried out in accordance with Bray, Lee, Smith, and Yorks (2000) direction, beginning with a structured guidance on how the groups would operate (see Appendix 4). It enabled the Debriefers to develop their own ideas and work together in a collaborative group to address matters of importance (see Appendix 5). The CI Group meetings lasted on average one hour eight minutes and were held in local fire station community rooms. The recorded meetings were transcribed verbatim by the principle researcher (see Appendix 8) and qualitatively analysed using Thematic Analysis, utilising guidelines from Braun and Clarke (2006) and Guest, MacQueen and Namey (2012). Spider Diagrams were drawn (see Appendix 10) to get a sense of themes. An overall model of Applied Thematic Analysis (ATA) was utilised as it is a combination of grounded theory; positivism; interpretivism, and phenomenology, merged to make one methodological framework, following the guidelines of Guest et al. (2012). Using the ATA approach enabled a rigorous, nevertheless inductive, set of procedures to be followed, devised to identify and examine themes from textual data in a manner that is transparent and credible. NVivo Mac is a qualitative data analysis computer software package which was used to assist with organising the data and represented Braun and Clarke (2006) description of the six phases of thematic analysis: familiarising with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes and producing the results; which ultimately resulted in six parent themes.

Methodological Implications

Due to the nature of the organisation, group members held dual roles, such as 'fire-fighter', which prevented them from committing to every CI meeting due to shift changes or industrial action. This is not typical of CI, as all members of a CI group would typically commit to attending all meetings and this could have affected the meetings content, therefore the interpretation of the results should be considered cautiously.

The second consideration is that of high emotion towards the organisation with regards to the policy and the way it was implemented when a fire-fighter sadly lost his life fighting a fire.

Limitations

The small sample size could be viewed as a limitation of the study, with the findings being indicative of these particular debriefers experiences at the time of the study, therefore findings such be considered cautiously. CI does however consider somewhere between five and 12 to be the number that allows for diversity, while still allowing the group to function democratically and with reasonable efficiency (Bray et al. 2000).

Whilst the findings of this study offer a valuable insight into the role of CID within a Fire and Rescue Service and are a reliable and valid examination of this group at this time, other debriefers will have their own individual experience guided by different policies and Fire and Rescue Services.

Future research considerations

Debriefers felt the views of 'debriefees' essential to get a true picture of CID within the organisation. Research with 'debriefees' using self-reporting questionnaires such as ‘General Health Questionnaire 28 (GHQ 28); ‘The Impact of Event Scale (Revised) – (IES-R) and ‘The Beck Depression Inventory II (BDI II) for example would provide data on trauma or distress symptomology. Future research directed at debriefees experiences of CID would extend these findings and should be considered.

Ethical Considerations

Ethical approval was acquired from the University of Chester Department of Social Studies and Counselling Research Ethics Committee and a letter of approval was received. After a presentation to the Fire Service Consultation, Research and Assurance Group (CRAG) by the principle researcher, permission was granted to conduct the research.

Engaging in trauma related discussions could evoke trauma memories (Seedat, Pienaar, Williams, & Stein, 2004). A ‘Support Information Sheet’ was distributed to volunteers regarding support they could access (see Appendix 3). There is a risk for some individuals to experience varying levels of distress, during or immediately after participation, although, these reactions do not appear to last (Legerski & Bunnell, 2010). Caution and awareness of participant’s wellbeing was carefully considered throughout the study. There was one occasion where the principle researcher felt

concerned for a participant and later sent a follow up email to ensure welfare and provide details of available support.

Vicarious Trauma (VT) is a term used to describe a condition that can arise when working with people who have experienced trauma. Administering trauma research can create the same potential risks to researchers as it can to trauma therapists (Rothchild, 2006; Figley, 2002). The Principle Researcher reduced the risk of harm by being mindful of vicarious trauma and maintaining overall wellbeing and utilising professional supervision. Chester Universities Department of Psychology's general principles of beneficence ('do positive good') and non-malfeasance ('do no harm') as laid out in the Declaration of Helsinki for the Conduct of Clinical Research, University of Chester Research Governance Handbook and BPS Code of Ethics and Conduct, were adhered to throughout the duration of the study (University of Chester, 2012; BPS, 2009).

Confidentiality

Participants' confidentiality was guarded at all times. The principle researcher arranged all CI meetings directly with participants. All meetings were held, at the request of participants, in community rooms within Fire Stations, away from Headquarters, to ensure confidentiality. All participants were given pseudonyms on any correspondence (see Appendix 8 & 9).

CHAPTER SIX

REFLEXIVE STATEMENT

CHAPTER 6

Reflexive Statement

The principle researcher employed a research diary; researchers' reflections on their actions, observations and feelings become data in their own right and are documented in research diaries (Flick, 2009; Etherington, 2004).

The principle researcher identified her influence in the research:

I feel drawn towards more pro-active approaches rather than rescue based interventions and included an example of a pro-active approach in the literature review. This was discussed in CI meetings; therefore, I feel I influenced this being included in this research. This is my passion and in my enthusiasm I discussed pro-active interventions, as I am drawn to these areas. The conversations during the meetings felt like they flowed and I was naturally contributing as a member of the CI group. Listening back I wondered if I should have been more restrained or would that go against collaborative inquiry?

The title evolved from *'What is the effect of 'A Fire and Rescue Service in the NW of England' CID Policy on the development of PTSD?'* to the current title, as debriefers felt they did not have enough trauma knowledge and did not feel they could answer the original title question. I felt this in itself was rich data as it highlighted their lack of knowledge and training in this area. The members of the CI Group all have a passion for this subject and have a genuine caring nature and the lack of training regarding trauma was disappointing and deflating for such dedicated volunteers.

I had no prior experience of CI and was guided solely by books and articles. I came across obstacles, such as industrial action and shift work, preventing debriefers, with dual roles as fire-fighters, from attending every meeting. I overcame this by distributing minutes, enabling the group to keep well informed of all the meetings contents. (see Appendix 9). Taking into consideration that it is unusual for group members not to attend all CI meetings, the group agreed that minutes would be the best solution. Being mindful of minutes becoming directive, I did not include action points, they were purely informative.

Due to organisational issues such as on-going industrial action and personal issues the research was delayed a number of times. This did not deter any of the CI Group members and their commitment and dedication remained throughout.

CHAPTER SEVEN

CONCLUSION

CHAPTER 6

Conclusion

In the light of the findings this study identified that Debriefers have a mutual conceded desire to help people and this was a strong commonality within the group. Improvements have been made since the introduction of CID, with a clearer understanding of mental health and PTSD, however, there are concerns about attitudes towards the CID policy and the way it is approached. The findings lend support for previous research that highlights concerns within CISD, such as the Cochrane Review (Rose et al. 2002) which recognised that there was a lack of appropriate training for those facilitating psychological debriefing and Durkin and Bekerian (2000) study which expressed little confidence in the relevant expertise of debriefers and the Home Office (2000) report 'Fit for Duty?' cautioning against a well-intended but uneducated intervention (p. 73, 21.25). The training incorporated within this policy does not appear to inform and empower by normalising common reactions to trauma and provide information regarding coping strategies as directed by Mitchell, (1983). Psycho-education and the benefit of explaining what to look out for and what are normal reactions to trauma were considered favourably. Debriefers feel that sharing experiences in a CID is particularly beneficial for people and believe CIDs are extremely worthwhile.

Debriefers do not feel they know enough about PTSD to comment whether CID helps recognise stress reactions that could lead to PTSD. Debriefers recognise CID is becoming accepted, however, believe there is much room for improvement, such as

implementing 'An introduction to CID' into the recruit-training programme, so employees recognise what the job entails and the support mechanisms available. The general consensus from debriefers is that there isn't a clear understanding of CIDs, making it difficult to reassure people about the policy and its intent. Debriefers feel CID is leaderless and described morale as extremely low. Debriefers are dedicated and passionate within this arena and give their time for free, yet feel undervalued and lack sufficient training. Debriefers feel they lack support and believe that implementing a support mechanism where they can meet as a group and share experiences would be beneficial.

Debriefers feel that EFCs are an important issue that should be raised urgently with regards to health and safety and protecting the workforce and should be incorporated into the CID Policy. The TRU are dealing with bigger more severe incidents across many station areas and the personnel are subjected to repeat traumas yet are not being monitored and an intervention is thought essential. Fire-fighters taking their own lives is a serious concern and the need for more awareness of available support within the organisation and the importance of direct communication was emphasised. Introducing 'Psycho-education' to all employees when they join the fire service was considered advantageous.

Debriefers confirmed that there is still a stigma attached to stress and people will try and conceal stress as they feel shame. People are afraid of admitting they are suffering and feel like they should be able to cope, especially men. Derogatory comments, especially from the older generation, such as *'you've just got to get on with it'* keep the stigma alive.

The findings identified that training to build resilience would be beneficial, to help people become more resilient. Additionally, pro-active Interventions were highlighted but further research was suggested in order to confirm validity.

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APPENDICES

APPENDIX 1

Tracy Ann Haynes
University of Chester

22 Nov 12 / Version 1

Title of Research Study:

What is the effect of 'A Fire and Rescue Service in the North West of England' Critical Incident Debrief Policy on the development of Post Traumatic Stress Disorder (PTSD)?

PARTICIPANT INFORMATION SHEET FOR DEBRIEFERS'

Dear Potential Participant,

Please read this sheet carefully.

You are invited to take part in a research study. Before you decide whether to take part in the study it is important that you understand what the research is for and what you will be asked to do. Please take time to read the following information and discuss it with others if you wish. It is up to you to decide whether or not to take part. If you decide to take part you will also be asked to sign a consent form. You can change your mind at any time and withdraw from the study without giving a reason.

What is this purpose of this study?

This study is looking at the effects of the Critical Incident Debrief Policy on the development of PTSD. The aims are to gain an insight into how the Debriefers perceive the debriefing process and firefighters preferences regarding post-incident interventions. This will give an overview of how the policy is received.

Why have I been invited?

As you are a 'Debriefer', I would like to ask you about your experiences and opinions of debriefing; this will provide valuable data from the lived experiences of those working within the policy.

Do I have to take part?

No you don't have to take part in this study. It is up to you to decide whether or not to take part. If, after careful consideration, you do decide to take part, you will be asked to sign a consent form. If you do decide to take part you are still free to withdraw from the study at any time and you do not have to give a reason.

Would my taking part in this study be kept confidential?

Yes, only members of the research team will have access to the audio recordings and transcripts of your recording, which will be kept in a locked secure place and all computer data will be protzected. No one in your organisation will be able to identify who has, or who has not, taken part in the research from the final report. Your names will not be used and no personal information about yourself will be given in the final report.

What happens if I take part?

If you do decide to take part, you will be invited, as one of the 21 Debriefers, to a group meeting called a 'Collaborative Inquiry Group'. Collaborative Inquiry Groups allow for people, who have similar interests and concerns, to work together to enable understanding and learning, to find out how to do things better. This kind of research works with people rather than on people. It will

enable the Debriefers to develop their own ideas and work together in a collaborative group to address matters of importance. All involved will work together as co-researchers, this will allow for involvement in the design and management of the study. With your permission the group sessions will be recorded and later transcribed. This is so the conversations can be written up, in order to conduct research on it. At the end of the research I will write a report and the results may be published in peer reviewed journals and conference presentations. No research participant will be identifiable from any publications.

What are the likely benefits?
More research into debriefing fire-fighters is needed to develop and improve processes and policies. Gathering information from those who work within the debriefing policy will provide valuable and knowledgeable data. It will give the users of the policy a chance to input their opinions and views, to find out if there is any room for improvement. The information gained from this research will be used to make recommendations for best practice. The results of the study may also lead onto further studies regarding the Debriefing process.

What are the potential risks?
As the nature of this study involves Post Traumatic Stress Disorder (PTSD) and psychological interventions such as debriefing, talking about traumatic experiences may be upsetting for you and can cause retraumatiation . Retraumatization can occur when people are describing in detail, a traumatic experience. Talking about the event in such detail can cause retraumatization, where you can experience the same traumatic impact as experienced at the time of the traumatic event. If you feel you would like some additional help, I will be able to advise you who to contact or you can refer to the 'Support Information Sheet' provided. If you have any concerns about any part of this study, please do not hesitate to contact me and I will do my best to answer your questions. You are free to stop participating at any time if you do not wish it to continue.

Complaints:
If you wish to make a complaint regarding the study, please contact: My Supervisor, Dr Stuart McNab, Centre for Research and Education in Psychological Trauma. Tel: 01244 512456 Email: s.mcnab@chester.ac.uk.

What will happen to the results of the study?
The results of the study will be published for thesis and submitted for publication. The organisation will be given a copy of the report to assist with making informed decisions regarding the future of the policy.

Who is organising and funding the research?
The research has been organised with the support of the University of Chester and is part of an MSc Dissertation.

Please do not hesitate to telephone me if you need further information. Thanking you in anticipation.

Yours sincerely

Tracy Haynes

APPENDIX 2

Tracy Ann Haynes

University of Chester

CONSENT FORM

Title of Project:

What is the effect of 'A Fire and Rescue Service in the North West of England' Critical Incident Debrief Policy on the development of Post Traumatic Stress Disorder (PTSD)?

Name of Researcher: Tracy Ann Haynes

Please initial all boxes

1. I confirm that I have read and understand the information sheet dated 22 Nov 2012 (version 1 for the above study). I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. ☐

3. I understand the potential risks involved in trauma research and have received an information sheet on where I can go for further support if required. ☐

4. I agree to the Collaborative Inquiry Groups being audio recorded. ☐

5. I agree to take part in the above study. ☐

Participants Name: _____

(PLEASE PRINT)

Date: _____

Signature: _____

APPENDIX 3

Tracy Ann Haynes

University of Chester

SUPPORT INFORMATION SHEET

Where to find professional help:

- **PMI Health Group – Occupational Health Provider for GMFRS through your line manager.**
- **Employee Assistance Programme Provide, PPC Worldwide on telephone – 0800 282 193 and on the web at: www.ppconline.info**
- Your Health and Wellbeing Advisor in Human Resources – **FSHQ ext 4247.**
- On Big Red: http://bigred/SiteCollectionDocuments/People/OH/Problems_Poster_2011.pdf
- Bereavement Support Team on **01204 390448.**
- Your GP can also offer you a local specialist.

Cont'd

SAMARITANS	08457 90 90 90	www.samaritans.org
RELATE (Relationship Problems)	0300 100 1234	www.relate.org.uk
PAY PLAN (Debt Counselling)	0800 280 2816	www.payplan.com
ALCOHOLICS ANONYMOUS 11.00-23.00hrs answer phone available out of hours	0845 769 7555	www.alcoholics-anonymous.org.uk
NATIONAL DRUGS HELPLINE	0800 77 66 00	www.urban75.com/Drugs/helpline.html
FRANK (Drugs Information**)**	0800 77 66 00	www.talktofrank.com
NATIONAL FAMILY MEDIATION SERVICE	0300 4000 636	www.nfm.org.uk
CRUSE BEREAVEMENT CARE	0844 477 9400	www.crusebereavementcare.org.uk
MACMILLAN CANCER SUPPORT	0808 808 0000	www.macmillan.org.uk
SMOKE FREE	0800 022 4332	www.smokefree.nhs.uk
MIND MENTAL HEALTH Monday-Friday 09.00-18.00hrs	0300 123 3393	www.mind.org.uk
BODY POSITIVE NW (Positive Living with HIV) 09.00 –21.00	0300 365 0070	www.bpnw.org.uk
BRIGADE CHAPLAIN	0161 743 3909	
MONEY ADVICE SERVICES	0300 500 5000	www.moneymadeclear.org.uk
DEPARTMENT FOR WORK AND PENSIONS		www.dwp.gov.uk
GOVERNMENT SERVICES		www.direct.gov.uk
LEGAL ADVICE	0845 345 4 345	www.communitylegaladvice.org.uk
HM REVENUE AND CUSTOM (TAX)		www.hmrc.gov.uk
PPC WORLDWIDE (EMPLOYEE ASSISTANCE PROGRAMME)	0800 282193	www.ppconline.info
MONEY SAVING EXPERT		www.moneysavingexpert.com/mentalhealth

PLEASE NOTE THAT GMFRS DO NOT ACCEPT ANY RESPONSIBILITY FOR SERVICES PROVIDED BY ANY OF THE ORGANISATIONS INCLUDED IN THIS ITEM

GREATER MANCHESTER FIRE AND RESCUE SERVICE

PREVENTING PROTECTING RESPONDING www.manchesterfire.gov.uk

APPENDIX 4

Tracy Ann Haynes

University of Chester

Title of Research Study:

What is the effect of 'A Fire and Rescue Service in the North West of England' Critical Incident Debrief Policy on the development of Post Traumatic Stress Disorder (PTSD)?

COLLABORATIVE INQUIRY GROUP STRUCTURE GUIDANCE SHEET

- Explanation of Collaborative Inquiry Groups
- Questions and Answers.
- Exploration of the research question (framing the question)
- Agreeing on the criteria that define the group
- Design of the Inquiry – devise of a plan
- Realistic meeting possibilities.
- Respect of Group ownership of ideas
- Signing of Contracts
- Audio recording of Collaborative Inquiry Groups

APPENDIX 5

Criteria Defining Collaborative Inquiry Group

Title of Study

An investigation of the experience of the role of

Critical Incident Debriefer in a

'Fire and Rescue Service in the North West of England'

Criteria	Description
The purpose of the inquiry is to make new meaning.	Each co-researcher has a store of information and experience, which acts as a resource for finding knowledge.
How Collaborative Inquiry is a leaderless group and all participants are equal as co-researchers.	All participants are equal contributors. While some members of the group may have more knowledge regarding certain issues or more status, all are equal co-researchers.
All co-researchers are on equal terms in addressing the research question.	All members of the group can influence the process of the research as co-researchers.
Participation in this research is voluntary.	All co-researchers are participating completely voluntarily and without coercion.
Commitment to the group is essential for the duration of the inquiry; however, the group recognises that due to the nature of the organisation it is not always possible.	All participants agree to be at each meeting, however, it has been recognised and agreed that due to shift patterns etc it is not always possible for all participants to be in the same place at the same time. As such it has been agreed that minutes from each CI meeting will be circulated after each meeting to keep all group members informed. The minutes will be a summary only they will not have action points therefore will not be directive.
Rotation of facilitating, time keeping, recording and summarising.	At the beginning of each CI Group meeting the group will decide who will be carrying out which role. This will be done on a rotating basis to avoid bias.
Collaborative Inquiry works with people rather than on people. All participants are co-researchers not research subjects.	Collaborative Inquiry believes that people are self-determining. Using self directed action and reflection as a group to produce meaningful research.

APPENDIX 6

Fire & Rescue Service Critical Incident Debrief Policy
and
An overview of Fire Statistics

The fire & rescue service in question, has 1700 fire-fighters and at the start of this research had 21 Debriefers (as @ 11 Oct 12), which included; six x Support Staff; one x Fire-fighter; seven x Crew Managers; four x Watch Managers; two x Station Managers; one x Control. All are trained in the role and are classed as 1st Contact Advisors and they apply on a voluntary basis. The Critical Incident Debrief Policy, was first implemented in 1997, and revised 01 February 2012. Its aims are to provide appropriate health and wellbeing interventions which seek to remove barriers and aid employees to remain in work. This supports the corporate plan 2011 – 2014 which details maintaining a committed, enthusiastic and healthy workforce and to develop and maintain a safe workforce with low rates of accidents and injuries to its people. The policy recognises that by the very nature of the role it is expected that fire-fighters and other operational staff will at times be involved in managing incidents which may be distressing / traumatic. Some incidents may be particularly horrific / threatening or upsetting in their nature. Other employees who are not directly involved at the scene, such as Control Room Operators; Fire Investigation Team and Support Staff may also be affected and should be included in any debrief process.

The CID Policy aims to; outline the approach which the Fire & Rescue Service takes to effectively manage the aftermath of critical incidents; provide a timely, high quality and confidential support service to employees; provide an opportunity to talk through potentially traumatic events; enable employees who have attended a potentially distressing incident to talk about their feelings and emotions in order to lessen its

effect and support those individuals who may require the additional support of Occupational Health or other health care professionals. It is implemented as 'effective trauma management' and has 3 critical stages; defusing; critical incident stress debrief and post debrief (CID Policy, 2012).

An overview of Fire Statistics

The Department for Communities and Local Government Fire Statistics, Great Britain, 2011 to 2012 report the following statistics: In 2011-2012 fire and rescue authorities attended 585,000 fires or false alarms in Britain. A total of 272,000 fires were attended. Around 71% were outdoor fires (193,000), e.g. road vehicles, refuse, grassland. A total of 44,000 (16%) were fires in dwellings. In 2011-12, there were 380 fire-related fatalities in Britain, 24 fewer than in 2010-2011 and lower than in any year in the last fifty years. The highest number of fatalities recorded was 967 in 1985-1986. Through the 1990s and 2000s there was a general downward trend. Three quarters (76%) of fire-related fatalities occurred in dwelling fires. The statistics in this publication are compiled from Fire and Rescue Service records of incidents attended by fire and rescue authorities across Great Britain (Department for communities and local government, 2012, pg. 10-12).

APPENDIX 7

Critical Incident Debriefs (CIDs) Implemented or Declined and Absence Statistics

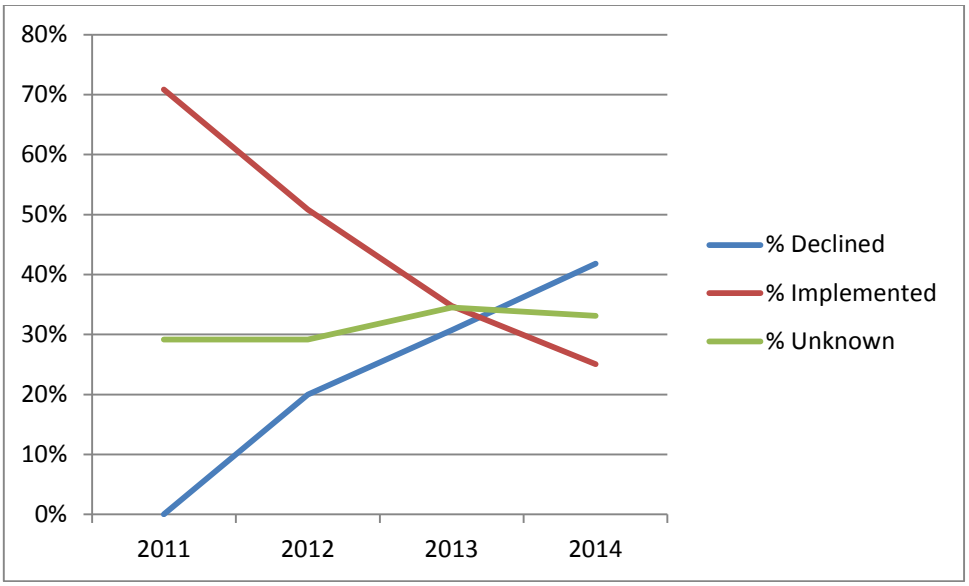
The following table and graph show the number and percentages of CIDs implemented or declined within this Fire & Rescue Station during 2011 to 2014.

Table 1: Number and Percentage of CIDs Implemented or Declined 2011 – 2014

	2011	2012	2013	2014
No. of Events	**11**	**42**	**60**	**30**
% Declined	0%	20%	31%	42%
% Implemented	71%	51%	35%	25%
% Unknown	29%	29%	35%	33%
Total	**100%**	**100%**	**100%**	**100%**

Table 2 and Figure 1 show that the number of CIDs implemented, within this particular Fire & Rescue Service, have significantly declined from 71% in 2011 to only 25% in 2014.

Figure 1: Number and Percentage of CIDs Implemented or Declined 2011 – 2014



It has been suggested that fire-fighters are at substantially higher risk for traumatic stress symptoms compared with other workers who do not work within the emergency services (Wagner, Mcfee & Martin, 2010). Table 2 shows the percentage of absence reported for mental health reasons within this particular Fire & Rescue Service during 2011 to 2014.

Table 2: Absence Stats for Mental Health Reasons 2011 – 2014

Time Period	MH as a % of sick days	% Increase
2011-12 Q3 - 2012-13 Q2	5.6%	N/a
2012-13 Q3 - 2013-14 Q2	6.4%	0.9%
2013-14 Q3 - 2014-15 Q2	7.1%	0.6%

Table 2 shows percentage absence for mental health reasons within this Fire & Rescue Station has risen over the period 2011 to 2014.[1]

The number of events being identified, as seen in Table 1, has increased significantly during the period 2011 to 2013, however, in 2014 the number of events identified halved compared to the previous year. This could be due to inaccurate record keeping or a change in the reporting system and therefore would not have an impact on the mental health of employees. The number of events implemented in 2011 was eight compared to 21 in 2012, 21 in 2013 and eight in 2014. In 2012 the CID policy was updated, therefore it could be assumed that the changes in events identified between 2011 and 2012 could be due to the policy change. A key member of staff with regards to CIDs went on long term sick during 2013 and this could have had an impact on the number of events both identified and being implemented during 2014. It would be expected that an increase in the number of CIDs being implemented would result in a reduction in the number of sick days relating to mental health. The

[1] Due to the availability of data it has only been possible to compare three years of absence data to four years CID data. In Table 1 data for each year is provided in an annual basis i.e. Jan-Dec.

figures in Table 2, due to their increase, do not show any evidence that the CID Policy is having an increasingly positive effect. However, the organisation has provided Mental Health Anti Stigma Training, which was delivered by Pennine Care NHS Foundation Trust, which may have reduced mental health stigma. This could have had an impact on employees' confidence in reporting mental health illness. Moffitt, Bostock and Cave (2014) found that 'Looking after Wellbeing at Work' (LWW) and 'Mental Health First Aid' (MHFA) courses were associated with significant improvements in attitudes and understanding towards mental illness. However, only 33.57% of management and 33.78% of operational staff within the organisation have attended this training up to now (as @ 27 May 2015).

APPENDIX 8

COLLABORATIVE INQUIRY GROUP MEETING TRANSCRIPT
17 OCT 2014

(5th Group Meeting)

In attendance:		**Roles:**	**Apologies**
Initiator:	Tracy Haynes	Recording Monitor	John (Pseudonym)
Debriefer:	Anne (Pseudonym)	Note Keeper	Harry (Pseudonym)
Debriefer:	Jay (Pseudonym)	Facilitator	
Debriefer:	Scott (Pseudonym)		

Before the recording device was switched on the Initiator greeted all debriefers as they arrived one by one.

A discussion was had as to who would carry out which role (please see above for the decisions). It was also agreed to focus on some of the points that were discussed in the fourth meeting with regards to areas that could have an effect on the development of PTSD (see from line 197, 2nd CI Meeting).

N.B. Two uniformed debriefers attended despite on-going industrial action.

TRANSCRIPTION

Initiator: Ok erm right this is the 5th and final collaborative inquiry meeting and I'd just like to say many thanks to everyone who's contributed and it is very much appreciated. Erm I'd also like to remind you that if you do have any problems or this brings anything up for you on the leaflet I gave out at the beginning it gives you all the available help erm but you've also got my contact details so if you needed me to direct you anywhere please feel free to ring me. Erm today its Jay who's facilitating so I'll hand over to you Jay.

Jay: So first of all if we go through err what was discussed at the last meeting a couple of us weren't here erm and it maybe that we can add to what's already been discussed and err recorded. Erm the first point that came up last time was the shared experiences and the impact of recognising that. Erm it was felt that Debriefers explain the process of sharing experiences and how that can help individuals themselves as well as helping somebody else. It is explained that even a sentence or a throw away comment that might be said can click in somebody else's mind. How the unknown can be worse than actually knowing as you start imaging (.) and it might not be as bad as somebody thinks. I didn't read that particularly well (laughing). Erm (.) So.

Scott: I get what you say err a shared experience because even though you might not have been if it was a house or a car at that point where the significant trauma was you might've been on the fringes you might've been err in (inaudible) back of the appliance sending a message. You might not have seen that (.) you might not have had to deal with that (.) however you soon learn that from the group discussion don't ya.

(1:59)

Anne: Umm that's what we th we said last time is sometimes the process that we have in the organisation isn't great because we invite everyone…

Scott: ((in overlap)) It exposes more people to the…

Anne: … to a de yeah and then people that were sat in the appliance who didn't actually see anything are sat then in a room with other people talking about their experiences and it kind of obviously …

Scott: ((in overlap)) Minute details.

Anne: … yeah starts ticking over in their mind and they do they need to know that. No. So…

(2:26)

Scott: Oh yeah it's tough in it because there'll be people going 'Well I didn't know what happened however I wanted to know what happened…

Anne: ((in overlap)) Umm.

Scott: … and I wanted to go in there and be involved.

Jay: Well they want to be part of the team as well don't they…

Scott: Yeah.

Jay: … they want to know what everybody else has experienced…

(2:38)

Scott: ((in overlap)) They want to share (.) share the experience.

Jay: Even if they ya know if they were there but not there like sat on the pump…

Anne: ((in overlap)) Yeah.

Jay: … ya know they (.) they do want to know what's gone on with every if you if ya miss a job…

Scott: Devastated.

(2:46)

Jay: If you on leave and you miss a job…

Scott: ((in overlap)) Oh devastated yeah.

Jay: …you know you don't wanna be there but then…

Anne: ((in overlap)) Umm.

Jay: …you want to be part of the group that's been involved in it…

Scott: Yeah.

Jay: …erm so on the periphery of an incident some people still want to be part of it to know (.) what's gone on.

Anne: Umm (.) but is that maybe just kind of a separate debrief like the hot debriefing type of arena…

(3:06)
Jay: Possibly.

Anne: …as a full critical incident debrief that you go into a lot of detail.

Scott: It (inaudible) where do you draw the line. Where do you separate people though…

Anne: Umm.

Scott: … when as soon as your mates have come out they've probably told you everything about it anyway…

Jay: Yeah.

Anne: Yeah. Umm.

Scott: … because that's your hot debrief fire brew whatever you want to call it. You automatically do it.

Anne: ((in overlap)) Yeah. Umm.

Scott: And then if someone wasn't there (.) when they come back everyone relives it again anyway.

Anne: Yeah true.

Jay: Yeah.

Scott: So it says…

Jay: I remember I remember from one debrief I did where it was a bit half the people didn't take part anyway err following the watch managers lead erm but the ones that did stay erm (.) particularly the Crew Managers sort of said at the end that he was really glad it happened because he was ya know there were bits that other people the gaps that other people filled in he had been thinking about the gaps and now he knew what the (.) ya know what the answer what the what had actually gone on ya know he found that really useful. Err so that particular sentence in there it I can erm I can relate to that one how people have ya know what people have said.

(4:13)
Initiator: Yeah so it's put someone's mind at rest…

Jay: Yeah.

Initiator: … cause otherwise their guess their guessing in certain bits.

APPENDIX 9

COLLABORATIVE INQUIRY MINUTES

17 October 2014 | 11:24 | Agecroft Fire Station

		Attendees (Pseudonyms)	**Apologies**
Meeting called by	Tracy Haynes (Initiator)	Anne – Note keeper	Catherine
Type of meeting	Collaborative Inquiry	Jay – Facilitator	John
		Scott – Time Keeper	Harry
		Tracy – Recording Monitor	

AGENDA TOPICS

Reminder of available help. |

Discussion: The initiator reminded the group that if they are experiencing any problems or that this research has highlighted any issues for them, the leaflet given out at the beginning of the research will direct them to all available help. She also reminded the group that they all have her contact details and are free to contact her at anytime, whereby she can direct them to appropriate help available.

Shared experiences and the impact of recognising that |

Discussion: It was felt that shared experiences do help, even if a fire-fighter had been on the fringes of an incident, as they learn missing details from the group discussion. One debriefer felt it could expose people to minute details they don't need to know about. However, a discussion was then had about people wanting to know what happened, as they want to be part of a team. They want to know what everyone else has experienced, even if they weren't directly involved i.e. sat on the pump. It was described as 'devastating' if you miss a job, as you want to be part of the group that has been involved. Even if on the periphery of an incident some people still want to be part of it. One debriefer asked if that should be a separate debrief such as the 'hot brew' rather than a full CID where it goes into a lot of detail. Another debriefer asked where you draw the line, where do you separate people. How the others involved automatically tell you everything anyway. One debriefer explained one CID where the Crew Manager expressed how useful he found it for filling in the gaps. A discussion was had how it can put someone's mind at rest; otherwise people are guessing certain bits of detail. It can bring a bit of closure rather than guessing and over thinking it, because people can worry that they've not done enough or that what they did wasn't quite right and a bit of false memory can occur. They can think they've done something that had a cause and effect, however the CID can reveal it actually might have been someone else's cause and effect, so it can be helpful in that respect.

Group dynamics |

Discussion: One debriefer said he wouldn't commit to saying the groups 'have a general good feeling', however they have seen a lot of change from when they first started. There are only a few now who will disrupt the CID, maybe walk out or not contribute, for their own personal reasons. One CID for example, that was run by external debriefers, didn't go well due to a particular station that was involved having an 'axe to grind' with the organisation. The debrief got overtaken with issues that weren't relevant to the incident, so another debrief was held excluding that particular group and it was much better. A discussion was had on how some people are naturally quieter than others; however, it was acknowledged that being quiet could also be a sign of other things. How the Watch Officers, by knowing their watch and observing people, should be able to notice if someone is overly quiet and it is not normally their character. How the CID does need some discipline and it is up to debriefers to manage it, as everyone has something to contribute. How there are always details in the background, such as an ambulance arriving late or the actions of a paramedic. How people need to vent sometimes. How there are also dynamics and affiliations within a watch, the way people operate and bounce off each other and that needs managing to a degree. Current issues also have

an effect, such as industrial action, where people are upset at the outset, especially if a manager is present. This can provide an opportunity to vent other issues, which may not be in the correct arena. However, this was felt to be limited as there are not many senior officers at present who are debriefers.

Organisation of CID |

Discussion: The rostering system is tight so may not allow for someone to attend a CID and it was felt that's not going to improve. A discussion was had about how there are not enough personnel to give flexibility to allow crew in to move people around. How people will do favours by swapping their shifts, however, that negates extra payment for detachment. How it can be difficult to get people in for a CID, they can live far away and are not willing to come in for a CID on their day off or how they could be on leave. It was felt that the organisation does not revisit the people who could not attend. How they used to send back up letters out, but not sure if that still happens. How HR start off with a list of who attended an incident, however, debriefers do not feedback attendance after a debrief. The question of who would be responsible for that was asked, would it be down to Watch Officers to acknowledge who's not had the opportunity to attend? Some people don't want to come in off duty no matter what, however, if they were paid they possibly would. It was acknowledged how it is very difficult to pin people down after an event, especially when it has been a large incident with more than one pump. It wasn't thought that there was anything in the policy regarding following up attendance with HR. The question was asked if this is something that needs including in the policy, taking into consideration confidentiality. Feedback of numbers of attendees rather than names, so not to single anyone out, therefore allowing for follow up with a general letter, could be a possibility. A discussion was had on the time scale between one CID and the next, as they are now less frequent. How they may miss the call requesting attendance at a CID if they are at work, unless they're deskbound. It was not known how the system works with regards to contacting debriefers to ask them if they can do a CID. There was a concern that CIDs seem to have dried up since moving to North West Fire Control. Another debriefer confirmed that they still get entered on the log; however, it was thought that HR then used to be sent an email form control to say if it had been declined on this occasion. It was thought that this might not be happening now from NW Fire Control. One debriefer explained he had had 3 fatals in the last 3 weeks and no one has had a CID for it, another debriefer asked if it met the criteria and a discussion was then had on how hard it is to look up the criteria on the Big Red. It takes too long and people can't find it easily enough, so give up looking and forget about it.

Reduction in Fires. |

Discussion: One debriefer described a lot of death and destruction that they are exposed to, of which only approx 10% is fires the other 75% being rescue, which doesn't make the press half the time. A discussion was had about how fires have reduced, how they have always raised awareness i.e. going to schools, it just gets publicised more now. Also they now have different campaigns at different times of the year and smoke alarms make a difference.

Levels of Irritatbility |

Discussion: One debriefer described how someone had pulled him aside after a debrief because he had noticed symptoms described in a CID, such as irritability, disrupted sleep patterns, being quiet or overly loud, in every person who had been on a particular job. He had initially said they didn't need a CID, but had subsequently noticed these symptoms and came forward admitting he had made a mistake and asked for a CID to be run. A discussion was had how people might not show symptoms straight away, how something else could trigger it a few weeks down the line. How describing symptoms for people to watch out for can be beneficial. One debriefer felt you don't have to dedicate a structured 5 minutes to stress symptoms or particularly go into detail, just skim over it. Another debriefer felt the organisation don't educate people to identify stress symptoms, however, acknowledged that there has been some mental health training recently. It was felt this was something that doesn't really matter to the organisation; however, it should as it could impact on sickness. It was felt that good Watch Managers should pay attention to people and pick things up, however, a couple of hours on mental health training doesn't really mean anything.

Poor Concentration. |

Discussion: Debriefers confirmed they are not trained enough in symptoms of trauma and giving advice to people. One debriefer explained that they are not there to coach people; they are not counsellors just facilitators. However, another debriefer thought that explaining signs and symptoms of stress isn't a bad thing.

Training . |

Discussion: Debriefers could not recall having any training on stress, they couldn't remember if they had or not. They felt that not remembering if they had received any training on stress symptoms; or not had any refresher training, could be example of why they need it.

Memory impairment . |

Discussion: Debriefers confirmed they wouldn't know if someone was experiencing memory impairment it would be something that fire-fighters colleagues would notice more. They explained they wouldn't even know, as debriefers, if someone's colleagues had noticed a problem, they just hope they would do something to help. It is something more the watch would look out for.

Impact on relationships. |

Discussion: Debriefers confirmed they have never known anyone mention their relationships within a CID. Again it is something the watch may be able to identify. One debriefer explained that the conversation is more around work and has never known anyone talk about issues outside of work. Debriefes felt they would be 'very surprised' and 'astonished' if relationship issues came up in a CID.

Levels of emotion. |

Discussion: A discussion was had on how frustration can be felt towards the public for taking photographs at incidents. Unfortunately social media is now a fact of life and it's not going to change as people have cameras on their phones. It is recognised that this is out of their control, but still it can be frustrating. A discussion was then had regarding anger being directed towards the ambulance service and the police and how others actions at incidents can raise anger. People have expectations how long something is going take and then it can then take considerably longer. Paramedics for example can have good days and bad days, however it was acknowledged how they are extremely busy and extremely stretched. It was felt that the majority of fire-fighters don't generally have a go at other fire-fighters in a CID. How people are still conscious and reluctant to point the finger of blame at somebody in what's still seen as an official gathering. They are more likely to talk about it to other members of the watch, or have a word with someone privately, as there is still a fear regarding confidentiality. They are more likely to point the finger at the other emergency services, as there's no come back from that.

Practical issues raised. |

Discussion: A discussion was had on how note taking is not permitted in a debrief, however, people are still suspicious of that. People think debriefers go out and write everything down and feedback to someone, like they are spies. Debriefers have to reinforce that that's not the case. It is felt that CID's have improved, in the sense of people getting up and walking out and people not wanting to be involved and just dismissing it completely. The fact that there isn't many CID's now, lead to a discussion of something being amiss with the policy. It was felt that the criteria are almost for extremes that are on the fringes, such as fatals involving a fire-fighter on duty or a family member. The day to day incidents, such as someone hanging or someone involved in a car accident, or anything blood and gory, just gets passed by, because it's not compulsory. People just say they are 'all right'. It was acknowledged that regardless of who you are, and as you change in life, grow older and have families, things can happen that might have a link, such as having a daughter the same age as a casualty. One debriefer felt the criteria for who can instigate a CID need altering to 'anyone's discretion'. However, it was acknowledged that people would still say they don't need it, as it is still seen as the 'manly thing to do'. One debriefer suggested one way of combating it could be to take into consideration how many someone's been exposed to in a certain length of time. Although it was acknowledged that this would be difficult to manage due to rostering, they may have been on a job somewhere else. The question was asked what happens with CID's with regards to other brigades due to surrounding brigades being utilised, if needed, because of the reduced number of appliances

and personnel, but the answer was not known. It was thought that they would not be invited to each other's CIDs, as like the Ambulance and Police, they have different policies in place. Would they be compatible? A discussion was had on how Fire and Rescue Services throughout England have different policies in place, such as TRiM, Occupational Health utilising trained Trauma Therapists and some not having any in place as yet. It was felt that there would be changes over the next few years to maybe a regional policy. One debriefer mentioned a CID she was involved in where Cheshire FRS attended an incident, but they did not attend the CID. She didn't know if they had been invited or not. A discussion was then had on TRiM and whether this could be something that could be considered for the TRU crews, as they pick up a lot more fatals and maybe require something different. One debriefer acknowledged as part of the TRU he's had 3 fatals in the last 3 weeks and not had anything different, because it didn't meet the criteria. It was acknowledged that a couple of people in the brigade have been TRiM trained but they are not debriefers. It was felt that it might be something the organisaton could be looking at, but did not know. The HR review was mentioned but debriefers are unsure whose role CID's comes under now. It was felt the role was being 'bandied about'.

Symptoms of stress. |

Discussion: The TRU being subjected to more fatals, but not meeting the criteria, was identified as something that could build up over time. One debriefer suggested looking at it in 3-month periods, as he has been subjected to 3 fatals in 3 weeks. The TRU are subjected to bigger and more severe incidents, 50%-60% are serious. It was thought that Station Managers could maybe monitor what their personnel have been exposed to, and have something in place that will trigger an intervention. A discussion was had how repeated trauma exposure does have an effect. How you can only file so much away before it has to be sorted out. It was acknowledged that the TRU has only been in place just coming up to a year and needs monitoring. One suggestion was for Watch Officers to do monthly reports. It was acknowledged that if the situation isn't monitored it could lead to problems, as 3-5 years down the line, when people have had numerous fatals and are suffering the effects; this could lead to claims coming in. Rather than the organisation implementing a system once there is a problem, it could be monitored now, which does not require that much more work. It may even transpire that it's just seasonal, i.e. the Christmas period. With regards to an individual noticing their stress, their GP was thought to be a fall-back, as that doesn't have an association with the job. It was known that you might have to wait 6 weeks or more if taking that route. It was acknowledged that someone can go to there Line Manager or PPC. A discussion was then had regarding PPC and how it had been used quite a lot after the fire-fighter had died. It was thought that there was good and bad feedback from that, however, it was felt the knowledge of its existence was in question. It is often displayed on screen savers on the desk tops and there used to be posters displayed, however, it was felt there needs to be more consistency so people can absorb it. People do not want to have to ask, as it is confidential, however it cannot be found easily enough on the Big Red. It was noted that the response is good from PPC, quicker than going to your GP as PPC is 24 hours, 7 days a week.

Previous Trauma's. |

Discussion: In the last meeting debriefers discussed how the trainer the organisation use said they shouldn't allow debriefee's to discuss previous trauma's, however, one debriefer had not heard this and felt he would be tempted to cut somebody off, depending on how far they were getting into it. A discussion was then had how you would want to let someone discuss a previous trauma a little bit, as they obviously have something to say. How they should be able to let debriefee's discuss it a bit and then rein it back in to the current incident, so as not to let it take over. Also, someone else may relate it to the current incident. It was felt that if someone had taken the time to bring a previous trauma up, it was significant enough to let them go with it. They may have been unconsciously waiting for an opportunity to talk and it could be upsetting for them and cutting them off too soon could finish the meeting. It could also be an opportunity to assess if that person is showing signs of other stress symptoms.

Willingness of fire-fighters to participate in Debriefings |

Discussion: It was felt that the willingness of fire-fighters to participate in debriefings is mixed and that there isn't too much negativity, however one debriefer felt it depends who is facilitating the debriefing. Another debriefer thinks it depends on who the Watch Managers are at the time. Debriefee's won't say anything in front of certain individuals i.e. ADO's, Area Managers or the Brigade Police and their presence can kill a CID. It wasn't thought that fire-fighters have any particular issue, more of a case of not having an understanding of what a CID is, especially if they have never attended one before. It is thought that there are not many people now who haven't been to a CID and how it would be interesting to know the percentages of who has and who hasn't attended a CID. It was acknowledged that a lot are declined.

Suicides. |

Discussion: The question was asked if CID's were held for the individual suicides within the brigade. A debriefer in a previous meeting had discussed a CID for the suicide of a fire-fighter. One of the debriefers acknowledged that a lot of his watch was rostered into that station that day and someone on his watch had to deal with the friend who had found him. The debriefer didn't know if he had had a CID for that as he had been talking to him about it a few weeks ago. The incident at Bolton where the main guy involved had been missed off the CID was discussed. It was felt that the statistics regarding suicides, so many in such a short period, was awful and shocking. It was also thought there were more than 4, as it was thought that someone who had recently retired took his own life also. All were from this Fire & Rescue service. There was animosity at the way the chief had just dismissed it. It was felt that senior managers could be dismissive.

Attendance criteria for a CID|

Discussion: Station Officers wanting to be involved in CID's when they haven't attended the incident was discussed. How Station Officers do not appreciate being told they cannot attend, it was felt that this is due to their ignorance and self-importance and they should have more knowledge about the policy these days.

Living locally to a Fire Station . |

Discussion: One Debriefer described how he had attended an incident in his local area recently, where he had administered CPR to somebody. Later that day he discovered, via Facebook, that the person had died, as someone on his friends list knew him and were posting tributes. Learning of his death via Facebook and seeing pictures of him and his family, made it more real for him. To be working on someone for 20 minutes at 6 O'Clock in the morning and then at 2 O'Clock that afternoon find out on Facebook that he had died is difficult. He then felt he had to inform the others of his death. A discussion was then had regarding resources and procedures with regards to finding out what has happened to people. How that information could get relayed from NWAS or the Hospital Trust, as people can end up going to a local hospital or being transferred to the other side of the country. It is often not known which hospital people have been taken to, especially if the Air Ambulance takes them, so a solution to this cannot be seen.

Debriefers and facilitating|

Discussion: A discussion was had regarding the more experience you have at debriefing the less you do it by the book. The debriefers in attendance explained how they do not use a classroom environment, with debriefers sat at the front. They think it's better to have everyone sat in a semi circle with debriefers sitting opposite each other; this enables them to signal each other. One debriefer remembered from the training that the leaning forward of debriefers was to signal the other debriefer.

Support for Debriefers|

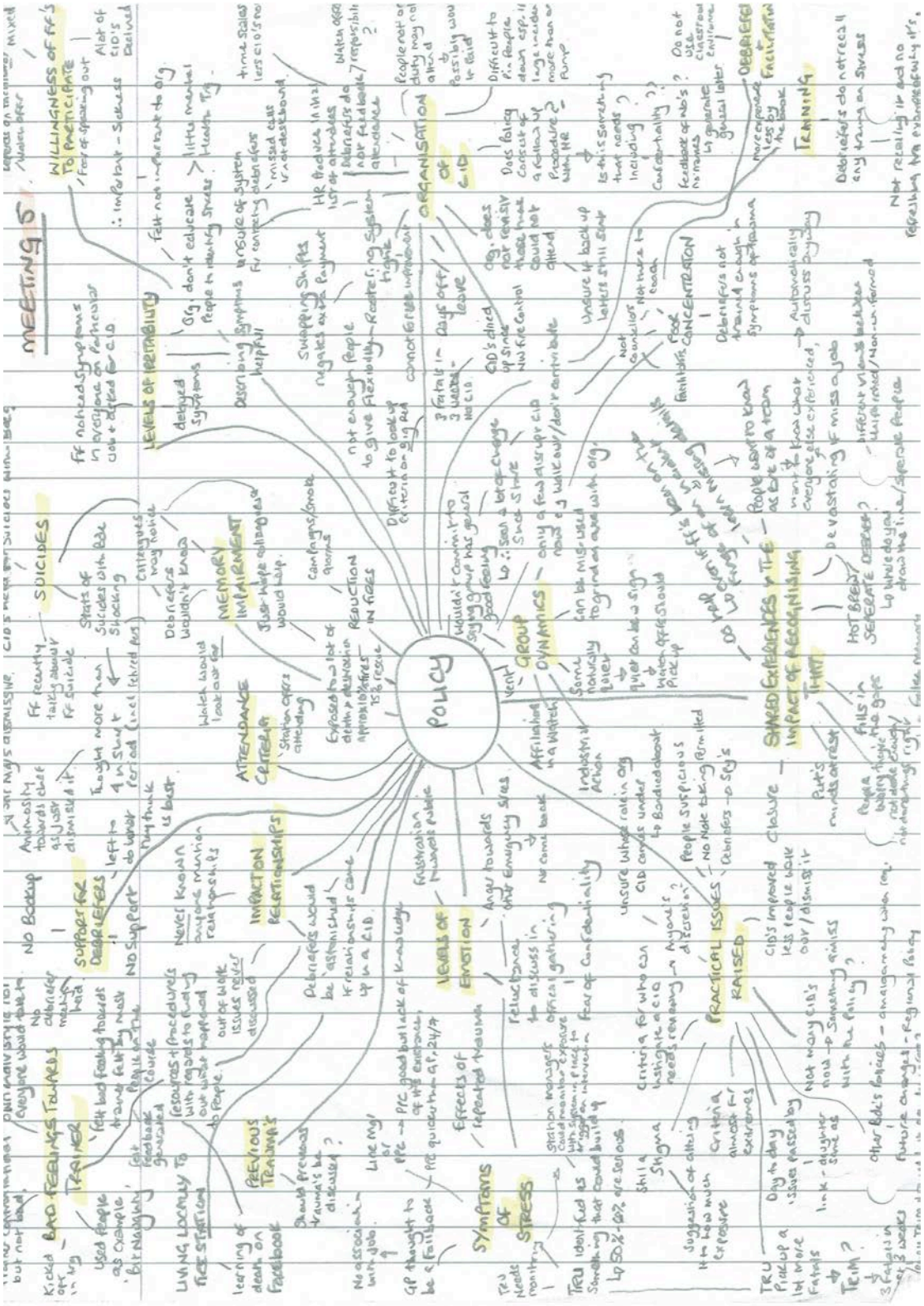
Discussion: The debriefers confirmed a point from the previous meeting regarding debriefers being left alone to do what they think is best with regards to a CID. They described it as having almost no backup, no support. Debriefers don't ever get together, they have 10 minutes at the end of a CID and then go home and then might not see each other for 6 months.

Any other business |

Discussion: The initiator asked if anyone had anything else they wanted to add and the debriefers confirmed they didn't.

All members were thanked for attending and the meeting was bought to a close after 1 hour and 8 minutes.

APPENDIX 10
SPIDER DIAGRAM FROM MEETING 5



APPENDIX 11
REQUEST TO FIRE & RESCUE SERVICES IN ENGLAND

Tracy Ann Haynes
University of Chester

To Whom It May Concern,

Re: Information Request

I would firstly like to introduce myself, my name is Tracy Haynes and I am currently doing a Masters Degree in Psychological Trauma at Chester University. As part of the degree I have to complete a piece of research with regard to Trauma.

The research I am doing is with regard to debriefing within the Emergency Services. As such I am interested to know if you have:

- **Implemented a Debrief Policy within your organisation yet?**
- **If so what type of debriefing you use?**

I would be grateful if you could email this information to me at: tracyhaynes1@hotmail.co.uk

Debriefing usually falls under what is called Critical Incident Stress Management (CISM) or a branch of that called Critical Incident Stress Debriefing (CISD). Organisations do use modified models of these or can outsource the debriefing to a specialised company.

I would be most grateful if you could supply me with the above information and help me to research this important area within the Emergency Services.

If you wish to confirm that I am a student at Chester University, please contact: My Supervisor, Dr Stuart McNab, Centre for Research and Education in Psychological Trauma. Tel: 01244 512456 Email: s.mcnab@chester.ac.uk.

Please do not hesitate to contact me if you have any further questions.

Many thanks in advance for your co-operation.

Best Regards

Tracy Haynes

APPENDIX 12
Fire & Rescue Services (England) - Critical Incident Policy
[In response to Appendix 11]

No.	FIRE & RESCUE SERVICE	CRITICAL INCIDENT POLICY	REMARKS
1	Avon	Not Known	
2	Bedfordshire	Not Known	
3	Buckinghamshire	Critical Incident Stress Management (CISM)	In final draft form
4	Cambridge	Not Known	
5	Cheshire	Psycho-Education/Psychological First Aid/ Impact of Events Questionnaire/Follow up Treatment	
6	Cleveland	Not Known	
7	Cornwall	Critical Incident Debriefing & Defusing	
8	County Durham	Debrief Policy more Ops based	
9	Cumbria	Critical Incident Debriefing (CID)	
10	Derbyshire	No policy implemented yet	
11	Devon & Somerset	Debrief Policy more Ops based	
12	Dorset	Trauma Risk Management (TRiM)	To be revised
13	East Sussex	Critical Incident Debriefing (CID)	
14	Essex	Form of Critical Incident Debriefing (CID) + Separate Counselling	Under review
15	Gloucestershire	Not Known	
16	Greater Manchester	Critical Incident Debriefing (CID)	
17	Hampshire	Debrief Policy more Ops based	
18	Hereford & Worcester	Not Known	
19	Hertfordshire	Debrief Policy more Ops based	
20	Humberside	Not Known	
21	Kent	Critical Incident Debriefing (CID)	
22	Lancashire	Critical Incident Debriefing (CID)	
23	Leicestershire	Form of Critical Incident Debriefing (CID)	
24	Lincolnshire	Critical Incident Stress Management (CISM)	
25	London	Procedure for Post Critical Incident Contact (PCIC)	
26	Merseyside	Critical Incident Stress Management (CISM)	
27	Norfolk	Critical Incident Debriefing (CID)	
28	Northamptonshire	No policy implemented yet	
29	Northumberland	Critical Incident Stress Management (CISM)	
30	North Yorkshire	Critical Incident Stress Debriefing (CISD) & EAP	
31	Nottinghamshire	Not Known	
32	Oxfordshire	Not Known	
33	Royal Berkshire	Proactive Approach	
34	Shropshire	Altered Mitchell Model	
35	South Yorkshire	Occupational Health Post Incident Support	
36	Staffordshire	Trauma Risk Management (TRiM)	

No.	FIRE & RESCUE SERVICE	CRITICAL INCIDENT POLICY	REMARKS
37	Suffolk	New policy being implemented in Jan 15	5 Stage Approach
38	Surrey	Critical Incident Stress Debriefing (CISD)	
39	Tyne & Wear	Trauma Support Programme	Mitchell Model
40	Warwickshire	Critical Incident Stress Debriefing (CISD)	
41	West Midlands	Critical Incident Debriefing (CID) & Trauma Risk Management (TRiM)	
42	West Sussex	Critical Incident Stress Management (CISM) & Critical Incident Stress Debriefing (CISD)	
43	West Yorkshire	Debrief Policy more Ops based	
44	Wiltshire	Not Known	